



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Division of Mental Health
and Addiction

Behavioral and Primary Healthcare Coordination Services

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Section 1: Introduction

This module documents the policies and procedures for the 1915(i) adult benefit provided through the Behavioral and Primary Healthcare Coordination (BPHC) program. State and federal requirements for BPHC service providers, eligibility determination, enrollment, service delivery, clinical documentation, and billing are also presented. This module is intended to be used in conjunction with the following resources:

- [Indiana State Plan Amendment \(SPA\) 13-013](#) approved by the Centers for Medicare & Medicaid Services (CMS)
- [1915\(b\)\(4\) Waiver](#) for the BPHC approved by the CMS
- *Indiana Administrative Code* [405 IAC 5-21.8](#) (Indiana rule for administration of the BPHC program)
- Indiana Health Coverage Programs (IHCP) policies and expectations issued by the Indiana Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP), including [Provider Reference Materials](#) and updates from [News, Bulletins, and Banner Pages](#) on the IHCP website at in.gov/medicaid/providers
- BPHC program information, including updates, policy revisions, and requirements for BPHC service providers issued by the FSSA Division of Mental Health and Addiction (DMHA) on the [DMHA website](#) at in.gov/fssa/dmha

BPHC-program-approved providers are required to review, understand, and follow BPHC program policies and procedures, as well as any subsequent updates or revisions issued by the CMS, DMHA, or OMPP. Failure to comply with State and federal regulations associated with this program and the expectations outlined in the provider module will lead to formal corrective actions, State and federal sanctions, and/or loss of approval as a BPHC provider.

On June 1, 2014, the Indiana FSSA changed the way individuals are determined eligible for coverage under the Aged, Blind, and Disabled Medicaid aid categories. Referencing the section numbers of the *Social Security Act*, Indiana transitioned from a “209(b)” state to a “1634” state. As an agency in a 1634 state, the IHCP began accepting all Social Security Administration (SSA) determinations of disability under the Social Security Disability Insurance (SSDI) program and automatically enrolling individuals determined eligible for Supplemental Security Income (SSI) benefits by the SSA. This change eliminated the arduous and duplicative requirement that Aged, Blind, and Disabled applicants who receive SSI also complete a second application with the IHCP. Also, neither SSI nor SSDI recipients now need to go through the State’s Medical Review Team (MRT) process to be determined disabled and eligible for IHCP coverage.

With the 1634 transition:

- Individuals receiving SSI benefits are enrolled in Medicaid automatically.
- The State accepts SSA determinations of disability.
- Individuals with incomes of up to 100% of the federal poverty level (FPL) who are aged, blind, or disabled are transitioned from spend-down to full Medicaid eligibility.
- The spend-down provision is discontinued.
- The income thresholds for the Medicare Savings Program, which provides Medicare cost-sharing assistance, are increased.

Section 2: Behavioral and Primary Healthcare Coordination Program Overview

The Behavioral and Primary Healthcare Coordination (BPHC) program was designed to help individuals with serious mental illness (SMI) and co-occurring physical healthcare needs manage their care by providing logistical support, advocacy, and education. In coordinating these needs, the goal is to empower BPHC members to remain integrated in the community. The BPHC program is targeted toward individuals who meet the BPHC eligibility criteria (see [Section 5: BPHC Member Eligibility Criteria](#) for additional information) and who would not otherwise qualify for Medicaid or other third-party reimbursement for the intense level of services needed to function safely in the community. The primary function of the program is to provide a gateway to Medicaid benefits for individuals who meet the BPHC eligibility criteria.

Note: Individuals who qualify for Medicaid without this program do not need to apply, because they will be able to access Medicaid services to meet their healthcare needs without this program.

BPHC Program

The BPHC program offers one service, *Behavioral and Primary Healthcare Coordination*, which consists of coordinated healthcare services to manage the healthcare needs of eligible members. The service includes logistical support, advocacy, and education to assist individuals in navigating the healthcare system, and activities that help members gain access to needed physical and behavioral health services to manage their health conditions.

The BPHC program is not designed to meet all of a member's needs, but merely to assist in the coordination of primary and behavioral/mental health services for the eligible member. BPHC members are eligible for Medicaid and to receive all Medicaid-covered services for which they qualify.

The BPHC program is intended for individuals with high-risk and severe behavioral health needs who are not otherwise eligible for Medicaid, Healthy Indiana Plan (HIP), or Hoosier Care Connect. No one is prohibited from applying for the BPHC program; however, individuals who are already Medicaid-eligible will have continued access to services similar in nature to BPHC, such as Medicaid Rehabilitation Option (MRO) and Adult Mental Health Habilitation (AMHH) case management, care coordination, and peer supports. Service units for BPHC are approved in conjunction with these other complementary programs; therefore, individuals would not receive additional service units or benefits by applying for BPHC.

Note: The BPHC program helps eligible individuals manage their physical and behavioral health. Community mental health centers (CMHCs) provide services such as help in scheduling appointments with doctors, coaching on communicating more effectively with doctors, and following doctors' instructions on medications or other recommendations.

Service Location

BPHC is a home and community-based services (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities are to be provided within the member's home (place of residence) or other locations based in the community. Service activities cannot be provided in an institutional setting.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide Medicaid HCBS. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the [Home & Community Based Services](#) page at [medicaid.gov](#). To view the HCBS Statewide Transition Plan, go to the [Home and Community-Based Services Final Rule Statewide Transition Plan](#) page at [in.gov/fssa](#).

In accordance with the HCBS Final Rule, a setting must exhibit the following qualities to be an eligible site for delivery of HCBS:

- Is integrated in and supports full access to the greater community
- Is selected by the member from among setting options
- Ensures member's rights to privacy, dignity, and respect, as well as freedom from coercion and restraint
- Optimizes autonomy and independence in making life choices
- Facilitates choice regarding services and providers

Additional requirements for provider-owned or -controlled home and community-based residential settings include:

- The member has a lease or other legally enforceable agreement providing similar protections.
- The member has privacy in his or her unit, including lockable doors, choice of roommates, and freedom to furnish or decorate the unit.
- The member controls his or her own schedule, including access to food at any time.
- The member can have visitors at any time.
- The setting is physically accessible.

The following are examples of settings that are **not** considered home or community-based:

- Nursing facility
- Institution for mental diseases
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Hospital
- Any other location that has the qualities of an institutional setting, including, but not limited to:
 - A setting located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment
 - A setting located on the grounds of or adjacent to a public institution, as defined in *Code of Federal Regulations 42 CFR 435.1010*
 - Any other setting that has the effect of isolating members receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

Requirements for Covered Services

For a service to be reimbursable under the BPHC program, it must meet the following minimum criteria:

- Be provided to an individual determined by the State Evaluation Team (SET) to be eligible for the BPHC program
- Be a service proposed on the member's Individualized Integrated Care Plan (IICP) and approved by the SET
- Be a BPHC service activity provided in a manner that is within the scope and/or limitations of the BPHC program, including provider qualifications, as described in this provider document
- Be supported in clinical documentation as a service or service activity that continues to promote stability for the BPHC member and enables the member to move toward obtaining the treatment and healthcare goals identified in the member's IICP

Noncovered Services

The following services are considered *noncovered* and are *not eligible for reimbursement* under the BPHC program (see [Section 14: Behavioral and Primary Healthcare Coordination Service](#) for additional service exclusions and limitations):

- A service and/or service activity provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, State, local, and private entities (for example, MRO)
- A service provided while the member is in an institutional or non-community-based setting
- A service activity that is provided in a manner that is not within the scope and/or limitations of the BPHC program
- A service or service activity that is not documented as a covered or approved service on the member's Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved IICP
- A service and/or service activity not supported by documentation in the member's clinical record
- A service and/or service activity provided that exceeds the limits within the service definition, including service quantity/limit, duration, and frequency
- Any service and/or service activity provided simultaneously with another service (only one of the services provided is billable)
- Activities billed under Behavioral Health Level of Need (LON) redetermination
- Activities billed under MRO Case Management
- Activities billed under AMHH Care Coordination
- The actual or direct provision of medical services or treatment, including but not limited to medical screenings such as blood pressure screenings or weight checks
- Activities billed under MRO or AMHH medication training and support
- Individual, group, or family therapy services
- Activities billed under crisis intervention services
- Time spent on the initial assessment, referral form, and IICP

Section 3: BPHC Service Providers

Behavioral and Primary Healthcare Coordination (BPHC) is delivered to eligible members by enrolled Medicaid providers. To become a BPHC provider, the potential provider must first be approved by the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and be enrolled in the Indiana Health Coverage Programs (IHCP), under the FSSA Office of Medicaid Policy and Planning (OMPP), as an approved BPHC provider agency. The approval is gained by meeting specific provider standards and criteria developed to ensure that BPHC members receive access to a full continuum of behavioral health services, provided in a manner that ensures the health and safety of those members.

Provider Agency Requirements

Community mental health centers (CMHCs) are the exclusive providers for the BPHC program, as authorized by the Centers for Medicare & Medicaid Services (CMS) under a 1915(b)(4) waiver. Any CMHC that wishes to become a BPHC provider agency must complete and submit a *CMHC Provider Application and Attestation to Provide Behavioral and Primary Healthcare Coordination* for review and approval by the DMHA. All BPHC providers must meet the following provider agency criteria and standards:

- In accordance with the federal CMS-approved 1915(b)(4) waiver, be a DMHA-certified CMHC in good standing with the DMHA and the OMPP, including adherence to criteria required of all DMHA-certified CMHCs
- Has acquired and maintains a national accreditation by an entity approved by the DMHA
- Is an enrolled State IHCP, or Indiana Medicaid provider that offers a full continuum of care (see the [Provider Enrollment](#) module)
- The CMHC attests that it is willing and able to provide BPHC services as described in the Medicaid-approved State Plan Amendment (SPA) and in this BPHC provider reference module. This criterion includes but is not limited to:
 - Must maintain documentation in accordance with Medicaid requirements defined under Indiana Administrative Code 405 IAC 1-5-1 and 405 IAC 1-5-3.
 - Must meet all BPHC provider agency criteria, as defined in the CMS-approved SPA and 405 IAC 5-21.8 of the *Indiana Administrative Code*.
 - Must employ provider staff eligible to provide BPHC services (see the [Provider Staff Requirements](#) section for additional provider staff requirements).

Note: Because CMHCs are deemed eligible to become BPHC provider agencies, DMHA and OMPP approval of interested CMHCs is required. Becoming a BPHC provider is contingent upon the provider agency meeting all BPHC provider requirements and standards.

Provider Agency Application

To become a BPHC provider agency, the CMHC must submit a *CMHC Provider Application and Attestation to Provide Behavioral and Primary Healthcare Coordination*, acknowledging the agency will adhere to the BPHC program policies and State requirements for all BPHC service providers, as described in this section. (See [Appendix C: CMHC Provider Application and Attestation to Provide BPHC](#) for a sample form.) The completed provider application should be returned to the DMHA director's office for review and approval or denial.

The DMHA documents approval or denial of the CMHC's application to become a BPHC provider agency. If the applicant is approved as a BPHC provider agency, DMHA will notify Indiana Medicaid to add BPHC to

the existing CMHC provider profile. Approvals are valid for up to 3 years (unless otherwise determined by the DMHA). Where possible, the DMHA aligns the BPHC provider agency renewal process with the routine CMHC certification timeline. Ongoing CMHCs that are approved to provide BPHC need to ensure compliance with the rules and regulations noted in the CMS [Indiana State Plan Amendment Attachment 3.1-I for 1915\(i\) Home and Community-Based Services Programs for Behavioral and Primary Healthcare Coordination \(13-013\)](#) and *Rule 405 IAC 5-21.8* for BPHC. If approved as a BPHC provider agency, the CMHC will have “Specialty 612 – 1915(i) BPHC Service Provider” added to its profile.

Provider Agency Expectations

DMHA and OMPP approval of a BPHC provider agency is contingent upon that agency complying with all Medicaid and BPHC program rules and policies. In addition to meeting BPHC provider agency requirements, the DMHA or the OMPP mandates that all BPHC provider agencies ensure that members are provided access to all of the services and supports needed to meet their individualized needs. Agencies approved to provide BPHC service activities are subject to the enforcement provisions in *405 IAC 1-1-6*.

BPHC provider agencies must adhere to the following:

- Ensure that all staffs providing BPHC services to members meet all standards and qualifications required for the BPHC service activity being provided. CMHCs are responsible for maintaining accurate and up-to-date files for each staff member, including but not limited to proof of BPHC training.
- Provide information related to the delivery of the BPHC program, members, and provider staff, as required or requested by the DMHA.
- Actively participate in the DMHA and the OMPP quality assurance (QA) program, ensuring compliance with all performance criteria set forth for the BPHC program (As required by the State, the agency shall participate in any quality improvement (QI) initiatives as they relate to the BPHC program).
- Participate in BPHC provider agency meetings, conference calls, and trainings provided or authorized by the DMHA or the OMPP.
- Comply with the DMHA policy regarding the reporting of critical incidents.
- Provide a system throughout the agency and network for handling individual complaints and appeals, including informing members of the availability of the toll-free Consumer Service Line (1-800-901-1133) for reporting complaints to the State.
- Cooperate fully with the processing of any BPHC-related complaint or appeal, including any corrective action plan (CAP) initiated by the State.
- Be compliant with all federal *Health Insurance Portability and Accountability Act* (HIPAA) and *Code of Federal Regulations 42 (CFR)* mandates and regulations in regard to consumer privacy and information sharing.
- Meet all clinical and operational standards and State requirements for a DMHA-certified CMHC.
- Maintain written policies and procedures for timely intake, screening, and comprehensive evaluation to ensure that members have access to appropriate mental health and addiction treatment services in a timely manner from the point the provider agency receives a referral for the BPHC program.
- If a BPHC provider agency is unable to provide the BPHC services, the provider agency is required to assist the member in selecting and ensuring linkage to a new BPHC-approved provider agency.
- Re-apply for approval as a BPHC provider agency every 3 years, from the date of initial approval as a BPHC provider agency, or as determined by the DMHA or OMPP.
- In addition to DMHA requirements for [BPHC provider agencies](#), all Indiana Medicaid-enrolled providers must assure compliance with rules and requirements specific to Indiana Medicaid

providers, which can be found on the [Provider Reference Materials](#) page at in.gov/medicaid/providers.

Provider Staff Requirements

CMHCs must be approved by the DMHA to become a BPHC provider agency. Licensed professionals, qualified behavioral health professionals (QBHPs), and other behavioral health professionals (OBHPs) employed by the BPHC provider agency may be eligible to provide all of the activities covered under the BPHC program. DMHA-certified recovery specialists (CRSs) and community health workers (CHWs) employed by BPHC-approved CMHCs may provide some of the activities within the BPHC service.

A [DMHA-approved BPHC provider agency](#) must ensure that the staff providing the BPHC service to members meets the specific criteria and standards required for the BPHC service activity being provided.

Licensed Professional

A *licensed professional* is defined as any of the following providers:

- Licensed physician (including licensed psychiatrist)
- Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *Indiana Code IC 25-23.6-10.5*

Qualified Behavioral Health Professional

A *qualified behavioral health professional (QBHP)* is defined as any of the following providers:

- An individual who has had at least 2 years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as previously defined, such experience occurring after the completion of a master's degree and/or doctoral degree in any of the following disciplines:
 - In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana
 - In pastoral counseling from an accredited university
 - In rehabilitation counseling from an accredited university
- An individual who is under the supervision of a licensed professional, as previously defined, is eligible for and working toward licensure, and has completed a master's and/or doctoral degree in any of the following disciplines:
 - In social work from a university accredited by the Council on Social Work Education
 - In psychology from an accredited university
 - In mental health counseling from an accredited university
 - In marital and family therapy from an accredited university
- A licensed independent practice school psychologist under the supervision of a licensed professional, as previously defined
- An authorized healthcare professional (AHCP), defined as follows:
 - A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *IC 25-27.5-5*

- A nurse practitioner or a clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person’s license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23*

Other Behavioral Health Practitioner

An *other behavioral health practitioner (OBHP)* is defined as either of the following providers:

- An individual with an associate’s or bachelor’s degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by the behavioral health service provider and supervised by a licensed professional (as previously defined) or QBHP (as previously defined)
- A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by a licensed professional (as previously defined) or QBHP (as previously defined)

Other Qualified Staff Members

DMHA-CRSs and CHWs employed by CMHCs may provide some of the activities within the BPHC service. CRSs and CHWs are not eligible to provide needs assessments, referral and linkage activities, or physician consults.

Certified community health worker (CHW) refers to an individual who meets the following criteria:

- Has completed the CHW DMHA and Indiana State Department of Health (ISDH) state-approved training program
- Receives a passing score on the certification exam
- Is supervised by a licensed professional or QBHP

Certified recovery specialist (CRS) refers to an individual who meets the following criteria:

- Is maintaining health recovery from mental illness
- Has completed the CRS DMHA State-approved training program
- Receives a passing score on the certification exam
- Is supervised by a licensed professional or QBHP

Note: Certified CHWs and CRSs are not permitted to complete the needs assessment, provide referral and linkage activities, or physician consults in the BPHC program.

A CRS eligible for reimbursement as a BPHC provider staff member must complete the DMHA/ISDH State-approved training and receive a passing certification exam score.

Section 4: Home and Community-Based Residence Requirements

Behavioral and Primary Healthcare Coordination (BPHC) is a home and community-based service (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities must be provided within the individual's home (place of residence) or at other locations based in the community. Service activities cannot be provided in an institutional setting. In addition, members must live in residential settings that meet the requirements of the [HCBS Final Rule](#) to be eligible to receive 1915(i) services, including BPHC.

In January 2014, the Centers for Medicare & Medicaid Services (CMS) published regulations to better define the settings in which states can provide services under the Medicaid HCBS program. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the [CMS Home and Community Based Services](#) site. See the [Service Location](#) section for additional guidance on HCBS requirements.

HCBS Statewide Transition Plan

The Division of Mental Health and Addiction (DMHA) adult 1915(i) program is implementing the Indiana HCBS Statewide Transition Plan (STP) to ensure that all settings in which HCBS are provided, as well as all residential settings in which HCBS members reside, must comply with the requirements of the HCBS Final Rule. On May 9, 2017, the CMS offered an extension from the previous deadline of March 17, 2019, to March 17, 2022, to those states that need additional time to comply with the requirements of the HCBS Final Rule. Direction from the CMS is that the implementation of the extension is at the discretion of the state; therefore, the DMHA 1915(i) adult benefits BPHC and Adult Mental Health and Habilitation (AMHH) programs will be adhering to the time frames outlined in the STP, which is to maintain the March 17, 2019, deadline. More information is available on the Family and Social Service Administration (FSSA) [Home and Community-Based Services Final Rule Statewide Transition Plan](#) page.

BPHC Members and Residential Facility Standards and Expectations

Many persons eligible for the BPHC program live in their own home, or with families or friends in the same manner as any adult who does not have a mental illness. Due to the eligibility criteria for the BPHC program, some persons seeking these services do not have family or friends with whom they can live or are not functioning at a level where their health and safety can be supported in a totally independent setting. Depending on the person's level of need (LON) and functioning, he or she may choose to live in a full-time supervised setting, a setting that provides less than full-time supervision, or a setting that provides no on-site supervision.

Before a member's selection of a residential placement, alternatives are discussed with the member, family, and guardian, as applicable. The decision for the choice of residence is based on the member's identified needs, goals, and resources. After the member chooses a residence, an Individualized Integrated Care Plan (IICP) is developed or updated with the member. The IICP reflects his or her aspirations and goals toward an independent lifestyle and how the residential setting contributes to empowering the member to continue to live successfully in the community.

The State defines *homelike*, to the extent feasible, as an atmosphere with patterns and conditions of everyday life that are as close as possible to those of members without a diagnosis of mental illness. This definition includes an environment designed with the purpose and focus to increase the resident's involvement in decisions that affect his or her care, daily schedules, and lifestyles to be more similar to his

or her peers who live on their own. The overall atmosphere of the setting is conducive to the achievement of optimal development of independence by the residents. The location of the facility must provide residents reasonable access to the community at large, including but not limited to the agency and medical, recreational, and shopping areas, by public or agency-arranged transportation.

The DMHA supports a permanent supportive housing model, which refers to a housing unit that is linked with community-based services. The tenant holds the lease with a landlord and receives services based on need through a community mental health center (CMHC). The tenant's housing is not contingent upon the person participating in any mental health or addiction services. The member has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the state, county, city, or other designated entity. Each member's essential personal rights to privacy, dignity, and respect, as well as, freedom from coercion and restraint are protected.

The DMHA expects the following standards to be maintained for BPHC) members living in a DMHA-approved residential setting:

- Approved residential settings can be individual/single occupancy dwellings or residences that support multiple individuals.
- DMHA-certified residential settings in, which some members may choose to live, will promote opportunities to assist and support each member to grow and develop skills needed to continue to live in the community.
- While the resident is in a DMHA-certified residential facility, the provider is responsible for ensuring the resident's involvement in decisions that affect his or her care, daily schedules, and lifestyle.
- The overall atmosphere of the setting is conducive to the achievement of optimal independence, safety, and development by the resident, with his or her input.
- The location of the facility must provide residents full access to the community at large, including but not limited to, the agency and medical, recreational, and shopping areas by public or agency-arranged transportation.
- The location, design, construction, and furnishings of each residence must be consistent with a family or personal home (homelike).
- The majority of services and behavioral healthcare are provided in locations outside the residence, such as in the community at large or in a clinic setting.
- Residents are afforded the opportunity to engage in community-based programs that assist them in achieving goals, including employment.

The DMHA has created an [HCBS member information pamphlet](https://www.in.gov/fssa/dmha) at [in.gov/fssa/dmha](https://www.in.gov/fssa/dmha) that helps explain the settings requirements for HCBS programs to members interested in selecting these services.

BPHC Resident Rights and Responsibilities

Under *Indiana Administrative Code 405 IAC 5-21.8*, BPHC members living in a DMHA-certified residential setting have the following rights:

- The environment is safe.
- Each resident is free from abuse and neglect.
- Each resident is treated with consideration, respect, and full recognition of the resident's dignity and individuality.
- Each resident is free to communicate, associate, and meet privately with persons of the resident's choice, as long as the exercising of these rights does not infringe upon the rights of another resident, and any restriction of this right is a part of the resident's individual treatment plan.

- Each resident has the right to confidentiality concerning personal information, including health information.
- Each resident is free to voice grievances and to recommend changes in the policies and services offered by the agency.
- Each resident has the right to manage personal financial affairs or to seek assistance in managing them, unless the resident has a representative payee or a court-appointed guardian for financial matters.
- Each resident shall be informed about available legal and advocacy services, and may contact or consult legal counsel at his or her own expense.
- Each resident shall be informed of the number for the DMHA toll-free Consumer Service Line (1-800-901-1133).
- Each resident shall begin receiving the BPHC services in a timely manner from the date of approval for services.
- Each resident has the right to privacy in his or her sleeping or living unit.
- Each resident has the right to units having lockable entrance doors, with only appropriate staff having keys to doors.
- When sharing living units, each resident has a choice of roommates.
- Each resident has the freedom to furnish and decorate his or her sleeping or living units.
- Each resident is able to have visitors of his or her choosing at any time.
- The setting is physically accessible to each resident.
- Each resident will be free from restraints, restrictive interventions, and seclusion.
- Each resident shall have the freedom and support to control his or her own schedule and activities, and have access to food at any time.

Any modification of the resident's rights must be supported by a specific assessed need and documented in the person-centered treatment plan, IICP.

Newly Identified Setting

When a provider identifies a new setting they want to make HCBS compliant, the provider is required to notify the DMHA at DMHAAdultHCBS@fssa.IN.gov to begin the assessment process. If the setting was established prior to March 17, 2014, and is currently serving HCBS-enrolled members, then the setting should have become HCBS compliant by March 17, 2019. If the setting was established after March 17, 2014, HCBS services can neither be delivered at that setting nor can any AMHH or BPHC enrolled member reside in the setting until the DMHA assesses the setting and deems it in full HCBS compliance.

DMHA-Certified Residential Facility Settings and Definitions

Members residing in a DMHA-certified residential facility settings described in this section are eligible to receive BPHC services. These community residential settings are designed to provide an array of living options that span the continuum from minimal oversight to highly supervised settings. The DMHA, through certification and licensure standards, requires the member's participation in planning his or her care, and supports the recovery philosophy that promotes the least restrictive and most appropriate care to safely meet the member's identified needs and preferences.

The DMHA-certified residential care settings are designed to be a component of an outpatient community-based continuum of care. These settings are not nursing facilities, intermediate care facilities for individuals with an intellectual disability (ICF/IIDs), or institutes for mental diseases (IMDs). The residential care settings do not have any qualities of an institution, nor would the settings be permitted to be located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or in a building on the grounds of, or immediately adjacent to, a public institution; or any other setting that has the effect of isolating members from the broader community. One of the primary goals of the BPHC program is to provide services and support to members to ensure that they live safely and as independently as possible in the community. The program intends to provide opportunities for members to meet their needs in community-based settings, and to prevent need for and placement in institutional settings.

The DMHA and OMPP have a strong partnership with State housing agencies: the Indiana Housing and Community Development and the Corporation for Supportive Housing. Together, these agencies have facilitated the development of supportive housing integrated into the community to meet the needs of members with mental health and addiction disorders.

The DMHA-certified residential settings in which some members may choose to live will promote opportunities that assist and support each member to grow and develop skills needed to continue to live in the community. The DMHA-certified residential living facilities include:

- Supervised group living (SGL) facilities
- Transitional residential services (TRS) facilities
- Semi-independent living program (SILP) facilities defined under *Indiana Code IC 12-22-2-3*
- Alternative family for adults (AFA) program homes operated solely by resident householders

Supervised Group Living Facility

A *supervised group living* (SGL) facility is defined by the DMHA as a residential facility that provides a therapeutic environment in a homelike setting to persons with psychiatric disorders or addictions who need the benefits offered in a group living arrangement as post-psychiatric hospitalization intervention or as an alternative to hospitalization. *Therapeutic living environment* means a living environment, in which the staff and other residents contribute, that presents no physical or social impediments to the habilitation and rehabilitation of the resident.

An SGL setting is designed to assist individuals in the recovery process by offering safe, supportive homelike environments. Individuals may come and go as needed to attend work, school, treatment appointments, recreation, and other activities in the community. On-site supervision is required 24 hours a day/7 days a week in this setting. Although individuals have access to food 24 hours a day/7 days a week, there are also typically planned meal times where individuals may eat together. Menus are developed by dietitians to provide healthy meals consistent with each individual's dietary needs and restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Consumers are given opportunities for input in the meal-planning process.

A certified SGL facility may serve up to 10 consumers in a single-family dwelling and up to 15 consumers in an apartment building (three or more living units) or in a congregate residence.

Transitional Residential Services Facility

A *transitional residential services* (TRS) facility is defined by the DMHA as a 24-hour-per-day setting that provides food, shelter, and other support services to individuals with psychiatric disorders and/or addictions, who are in need of a short-term supportive residential environment.

Individuals in this type of setting are provided with less than 24-hour supervision. Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments,

recreation, and other community activities. Although individuals have access to food 24 hours a day/7 days a week, there are typically planned meal times where individuals may eat together. Consumers are given opportunities for input in the meal-planning process. Menus are designed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. Individuals in this setting are likely preparing for, or already participating in, work or school activities. A certified TRS facility serves 15 or fewer persons.

Semi-Independent Living Facility

A *semi-independent living program* (SILP) facility is defined by the DMHA as:

- A facility that is not licensed by another State agency and serves six or fewer individuals per residence who have a psychiatric disorder or an addiction, or both, who require only limited supervision
- A facility in which the agency provides a resident living allowance to the resident, or owns, leases, or manages the residence

Individuals in this type of setting are provided with a minimum of oversight (that is, 1 hour per week). These settings are typically homelike. Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and other community-related activities. While individuals have access to food 24/7, there are typically planned meal times where individuals may eat together. Individuals are given opportunities for input in the meal-planning process. Menus are designed by dietitians to provide healthy meals that are consistent with each individual's dietary needs and restrictions (for example, diabetic, low sodium). Alternative food is available if an individual chooses not to eat the planned meal. This setting is intended to prepare individuals for independent living settings.

Alternative Family for Adults Program Homes

An *alternative family for adults* (AFA) program home is defined by the DMHA as a home that serves six or fewer individuals who have psychiatric disorders or addictions, or both, and reside with an unrelated householder.

Individuals in this type of setting are provided with a minimum of oversight (that is, 2 hours per month). These settings are homelike. Individuals have input into household activities and may come and go as needed to attend work, school, treatment appointments, recreation, and other community-related activities. While individuals have access to food 24/7, there are typically planned meal times where individuals may eat together. Individuals are given opportunities for input in the meal-planning process. Alternative food is available if an individual chooses not to eat the planned meal. This setting is intended to prepare individuals for independent living settings, or may become permanent housing if this best meets the individual's needs and a less-restrictive setting is not wanted or deemed appropriate by the individual or treatment team.

State Monitoring

The State retains the authority to monitor and enforce the adherence to standards by conducting on-site visits to ensure compliance with standards and respond to any complaint or incident reported. In addition to consumer feedback and site visits, data is collected and analyzed. There are also facility requirements for compliance with fire and safety codes, which must be kept up to date. The State will conduct site visits to ensure standards are met. Individuals residing in any DMHA-certified residential setting have the freedom to choose how they live, and residents' rights are respected and honored.

All settings in which an HCBS member resides or receives HCBS services must fully comply with the CMS Settings regulation. For this reason, setting assessments are not limited to only those provider owned, controlled, or operated (POCO) settings owned, controlled, or operated by CMHC. The AMHH and BPHC provider agencies must ensure that HCBS members in all POCO and non-POCO residential settings also meet the intent of the regulation. The DMHA State Evaluation Team (SET) will make the final determination of the setting compliance.

The Indiana HCBS STP describes how the SET will conduct ongoing monitoring of settings that were identified by AMHH or BPHC enrolled providers and assessed by the DMHA SET. Beginning state fiscal year (SFY) 2018, the SET assesses those AMHH or BPHC POCO residential and non-POCO residential settings that require physical changes to their setting to meet the CMS HCBS requirements. Those physical changes, for example, could be adding locks on bathroom and bedroom doors and/or posting and/or updating documents in the setting. For those HCBS compliant settings that do not require physical changes, the POCO residential and POCO non-residential settings will be monitored to ensure the HCBS requirements remain in compliance. When possible, the SET schedules their settings site visit with the agency's annual BPHC quality assurance (QA)/quality improvement (QI) visit. When this is not feasible, the SET works with the provider to schedule another time to conduct their settings visit. As of December 2018, all POCO settings that required physical remediation were visited to ensure compliance with the HCBS Final Rule.

Incident Reporting

Incident reports must be completed and submitted according to the timelines specified in the instructions on the *Critical Incident Report* form that was sent to each agency electronically. Following the form instructions, the provider needs to complete only *one* setting/benefit section, but must complete *all* areas of consumer status before submitting the report to the DMHA.

All critical incident reports are submitted via the online [Critical Incident Reporting](#) portal. The online form includes the option for providers to select from the following types of incidents:

- Serious Bodily Injury
- Fire/Explosion
- Suicide Attempt
- Emergency Room Visit
- Elopement
- Police response
- Alleged exploitation, abuse, or neglect
- Suicide
- Death
- Assault
- Seclusion and restraint (BPHC/AMHH)
- Medication Error (BPHC/AMHH)
- Other

The BPHC box must be checked to identify the consumer as a BPHC consumer.

Section 5: BPHC Member Eligibility Criteria

The Behavioral and Primary Healthcare Coordination (BPHC) program is offered as a part of a Medicaid State Plan option for providing 1915(i) Home and Community-Based Services (HCBS) to promote and empower independence and integration into the community and as an alternative to an institutional level of care (LOC). This 1915(i) option allows Indiana to offer HCBS to individuals who meet specific target group, needs-based, and financial eligibility criteria.

Conflict of Interest and Eligibility Determinations

To ensure there is no conflict of interest in the BPHC eligibility determination, the responsibility for the BPHC program clinical eligibility and approval of BPHC services, in all cases, is retained by the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET). Members of the SET are prohibited from having any financial relationships with the applicant or member requesting BPHC services, the families, or the provider agency selected to provide BPHC services.

BPHC service provider agencies are required to have written policies and procedures available for review by the State that clearly define and describe how conflict-of-interest requirements are implemented and monitored within the agency to protect individuals applying for BPHC services and the integrity of the BPHC program.

BPHC Service Member Eligibility Criteria

Indiana has elected to target the 1915(i) State Plan HCBS benefit for a specific population, as defined in *Indiana Administrative Code 405 IAC 5-21.8*, in the BPHC State Plan Amendment (SPA), and in this section of this module. An eligible member undergoes a face-to-face evaluation with the required credentialed staff of a DMHA-approved BPHC service provider agency. The SET assesses the BPHC application to determine if the individual meets the BPHC eligibility criteria described in this section. See [Section 6: Member Application for BPHC](#) for additional information regarding the BPHC service evaluation process.

Target Criteria

To be eligible for BPHC, an individual must meet the following target group criteria:

- Is 19 years old or older
- Has been diagnosed with a BPHC-eligible primary mental health diagnosis. The eligible diagnoses list includes, but is not limited to, the following general categories:
 - Schizophrenic disorder
 - Major depressive disorder
 - Bipolar disorder
 - Delusional disorder
 - Psychotic disorder

Note: Eligibility for the BPHC service requires at least one qualifying diagnosis. For the most up-to-date list of qualifying ICD-10 diagnosis codes, see Behavioral and Primary Healthcare Coordination Codes, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Needs-Based Criteria

Based on the behavioral health clinical evaluation, referral form, supporting documentation, and DMHA-approved behavioral health assessment tool results, the applicant must meet all of the following needs-based criteria:

- Demonstrated needs related to management of his or her behavioral and physical health
- Demonstrated impairment in self-management of physical and behavioral health services
- A health need that requires assistance and support in coordinating behavioral and physical health treatment
- A recommendation for intensive community-based care, based on the uniform DMHA-approved behavioral health assessment tool, as indicated by a rating of 3 or higher

Note: If an individual appears to meet target- and needs-based criteria for the BPHC service but is not enrolled in Medicaid, the following application steps are recommended to be completed simultaneously:

- 1) Submit BPHC application to the DMHA for clinical eligibility determination.*
- 2) Link applicant with the FSSA Division of Family Resources (DFR) to submit a Medicaid application.*
- 3) Link applicant to the Social Security Administration (SSA) for a disability evaluation.*

Financial Criteria

Determination of financial eligibility is conducted by the DFR. If an individual meets the criteria for being determined disabled, an increased income limit may be applied for the financial criteria determination. Individuals deemed disabled must have countable income at or below 300% of the federal poverty level (FPL). These income limits are updated annually when the federal government releases the new FPL standards. Annual updates can be accessed in the [Federal Register](https://www.federalregister.gov) at federalregister.gov on publication. The updates are typically published in late January and become effective in March or April. There are certain income disregards that may be applied, which may lower countable income. There is no asset limit for the program. For any individual who is not deemed disabled, standard Medicaid eligibility criteria is applied to determine eligibility. Information on the changes to Aged, Blind, and Disabled (ABD) Medicaid members is available on the FSSA website at [in.gov/fssa](https://www.in.gov/fssa).

Other Criteria

To be eligible for BPHC, an individual must reside in a home or community-based setting that is compliant with the requirements of the HCBS Final Rule (see [Section 4: Home and Community-Based Residence Requirements](#)). Each setting must be assessed independently to determine if an applicant resides in a community-based setting. Individuals in institutional settings are not eligible for the BPHC program. However, BPHC applications can be initiated by the community mental health center (CMHC) in advance of an individual's discharge as part of the discharge planning process (see [Section 6: Member Application for BPHC](#)).

Additionally, individuals must meet all other Medicaid eligibility requirements such as citizenship and state residency requirements, as determined by the DFR. An application to the SSA must be filed for Indiana Medicaid to complete the eligibility process. For individuals who have an SSA disability determination, the State will use this determination for Medicaid eligibility purposes. Individuals considered disabled by the SSA will be considered disabled by Indiana Medicaid.

Note: [Healthy Indiana Plan](#) (HIP) members who are deemed medically frail are enrolled in HIP State Plan Plus or HIP State Plan Basic. These members may apply for the BPHC program through the normal BPHC application process. If they are found to meet BPHC clinical and non-clinical eligibility criteria, they will be transitioned out of HIP and enrolled under fee-for-service Medicaid to receive BPHC services. For all financial eligibility questions, contact the Division of Family Resources (DFR).

[Hoosier Care Connect](#) members who meet the needs-based criteria may be eligible to participate in BPHC.

[Hoosier Healthwise](#) members age 19 or older who meet the needs-based criteria may be eligible to participate in BPHC.

An applicant not meeting the target group, needs-based, financial, and other criteria as previously defined will not be eligible to receive the BPHC service under the 1915(i) State Plan HCBS program. When applicable, the CMHC shall facilitate linkage to alternative services that may meet the applicant's needs.

Section 6: Member Application for BPHC

For an individual to receive the Behavioral and Primary Healthcare Coordination (BPHC) service, a BPHC provider agency, in collaboration with the individual seeking the service, must submit a BPHC application packet to the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) in the manner required by the FSSA Office of Medicaid Policy and Planning (OMPP) or DMHA. This section outlines the referral and application processes used to assist DMHA in determining an applicant's clinical eligibility for the BPHC program.

Referrals for the BPHC Program

Referrals to the BPHC program may come from any source within the community, including but not limited to:

- Community mental health centers (CMHCs) or other treatment providers may identify individuals who appear to meet the eligibility criteria
- Individuals may notify their provider of an interest in the BPHC service
- An individual's family members or caregivers may inquire about the service and assist the individual in contacting a DMHA-approved BPHC provider agency

Note: No one is prohibited from applying; however, individuals who qualify for Medicaid without this program do not need to apply for the BPHC program, because they will be able to access Medicaid services to meet their needs without this specialized service program.

Information about the BPHC program may be obtained from BPHC service provider agencies, as well as on the Indiana DMHA [Behavioral and Primary Healthcare Coordination](http://in.gov/fssa) page at in.gov/fssa. The website provides a summary of the eligibility criteria, and notes all BPHC service provider agencies and the locations where potential enrollees may go to apply, as well as how to access a BPHC assessment.

If an individual seeking the BPHC service contacts the State for information, the interested individual will be referred to the DMHA-approved [BPHC provider agencies](#) within the State that are authorized to assist the applicant with information about the BPHC program. These providers will help the individual complete the application and evaluation required to determine BPHC service eligibility.

Only the DMHA-approved BPHC provider agencies may submit BPHC applications. The BPHC provider agency reviews the eligibility criteria and service options with an individual interested in exploring the BPHC program as a treatment option. Together, the individual and provider will determine whether to complete an application for the BPHC program. The BPHC service will not be eligible for reimbursement for any individual who has not completed the BPHC application process, been determined clinically eligible for the service by the DMHA State Evaluation Team (SET), and determined eligible for the Indiana Health Coverage Programs (IHCP) by the FSSA Division of Family Resources (DFR).

Note: The BPHC service is not eligible for reimbursement for any individual that has not been determined clinically eligible by the DMHA and IHCP-eligible by the DFR.

Activities Required Prior to Creating a BPHC Application

Before a BPHC application is created in the Data Assessment Registry Mental Health and Addiction (DARMHA) system, several activities must be completed, and documentation that the activities have occurred must be retained in the applicant's clinical record. These activities include:

- A qualified BPHC assessor must perform a face-to-face comprehensive biopsychosocial assessment.
- A qualified Adults Needs and Strengths Assessment (ANSA) user must conduct a face-to-face interview with the member and must complete a level of need (LON) assessment within 60 days prior to the submission of the BPHC application, which needs to be submitted in the Data Assessment Registry Mental Health and Addiction (DARMHA).
- The HCBS Residential Setting Screening Tool (RSST) (see [Section 7: Completing the HCBS Residential Setting Screening Tool](#)) must be completed with the applicant, and the [HCBS member information pamphlet](#) must be provided to the applicant.

Provider Requirements for Face-to-Face Evaluations

Only DMHA-approved BPHC provider agencies may conduct the face-to-face clinical evaluation required for the BPHC application process. Additionally, the BPHC provider agency must ensure that the agency staff member providing the face-to-face clinical evaluation meets the following minimum qualifications:

- Conducts the evaluation face-to-face with the client.
- Possesses at least a bachelor's degree in social sciences or related field, with 2 or more years of clinical experience.
- Has completed the DMHA or OMPP-approved training for the BPHC program, which provides an overview of the program and application process (It is the responsibility of the CMHC to ensure that appropriate documentation demonstrating compliance with training requirements is in the staff file).
- Is a certified ANSA user receiving supervision from an ANSA SuperUser.

Evaluation for BPHC Member Eligibility

Before completing the BPHC application process, the DMHA-approved BPHC provider staff will discuss the benefits and purpose of the BPHC program with the applicant. Next, the provider will assist in identifying whether the applicant meets the BPHC eligibility criteria. If the applicant is interested in pursuing an application for the BPHC program, the BPHC provider will work with the applicant to complete the application process.

Each BPHC applicant must undergo a face-to-face, biopsychosocial evaluation and needs assessment **and** the DMHA-approved behavioral health assessment – the ANSA. The evaluation includes the following:

- Review, discussion, and documentation of the applicant's strengths, needs, desires, and goals, specific to the mental health/substance abuse and physical health needs identified by the applicant
- Review of psychiatric symptoms and how they affect the applicant's functioning and ability to attain desires and goals, as well as the applicant's ability to self-manage mental and physical healthcare services

Note: The BPHC clinical assessment must be a face-to-face, individualized contact with a qualified provider staff member. The face-to-face clinical assessment may be conducted in conjunction with or separately from the ANSA assessment.

- Review of the applicant's health issues and need for support and assistance to manage them due to mental illness
- Identification of any physical health conditions that the applicant is having difficulty managing due to his or her mental illness
- Review and verification that the behavioral health diagnosis is current and accurate and is an eligible BPHC diagnosis.
- Completion of an ANSA, if one has not been administered within the last 60 days. Although the person completing the BPHC face-to-face clinical evaluation described previously in numbers 1-5 must have a bachelor's degree with 2 or more years of clinical experience, the ANSA for the BPHC application may be completed by any BPHC provider staff member, who is certified by the DMHA to complete the ANSA

Note: The State has not defined specific medical conditions required for an individual to be eligible for BPHC; rather, the individual must have a serious mental illness (SMI) that impacts his or her ability to manage physical health matters. Evidence of being unable to manage physical health matters could include issues such as lack of an established medical home, frequent emergency room visits, need for a physical or ongoing preventive care, or inability to self-manage any prescribed medications.

The evaluation also explores and includes documentation on the following:

- Applicant's living situation to ensure that it meets BPHC criteria (see [Section 5: BPHC Member Eligibility Criteria](#) for additional information)
- Documentation that provides support and justification for the applicant's co-existing physical healthcare needs, and the need for support and assistance to manage them due to his or her mental illness (See the [Additional Medical and Coordination Indicators](#) section for more information.)
- Documentation of current needs and strengths to support the need for the program and service
- Indication of what other behavioral health programs and services the applicant has or is likely to participate in (for example, Medicaid Rehabilitation Option [MRO]/Adult Mental Health Habilitation [AMHH]/Medicaid outpatient mental health services)
- Documentation of any other case management and care coordination services being used by the applicant, such as home and community-based services (HCBS) waiver
- Documentation of the physical health services necessary to assist the applicant in remaining in the community (for example, primary care, specialty care, and so on)

Incomplete BPHC Application

All required fields must be filled out on the BPHC application or it will not be accepted. If all fields are completed but there is insufficient or inconsistent information for a clinical determination to be made, the SET may deny or pend the application and request additional information from the BPHC provider agency, as described in [Section 10: SET Determination of BPHC Service Eligibility – Initial BPHC Application](#). If the application is placed in the pending status, and the required information is not submitted in the Data Assessment Registry Mental Health and Addiction (DARMHA) within 7 calendar days of the SET's request, the BPHC application will be subject to denial. However, the provider agency may submit an updated BPHC application at a later date for team consideration. To ensure no conflict of interest in the BPHC clinical eligibility determination, the DMHA SET shall retain the authority to determine an applicant's clinical eligibility for the BPHC program and authorization to utilize the BPHC service.

Note: Applications placed in pending status must be updated as directed and resubmitted within 7 calendar days, or the application will be subject to denial.

Providing Written Statement of Rights

The BPHC provider staff ensures a written statement of rights is provided to each BPHC applicant and member. The statement includes:

- The toll-free Consumer Service Line, 1-800-901-1133, and the telephone number for Indiana Disability Rights (317) 722-5555 or toll-free at 1-800-622-4845
- Documentation that agency staff has provided both a written and an oral explanation of these rights to each applicant or member

Proposed BPHC Plan of Care

The agency provider staff and the applicant jointly develop a proposed Individualized Integrated Care Plan (IICP) that includes identified strengths, needs, the applicant's desired goals, and choice of provider agency. The IICP also includes the proposed BPHC activities deemed necessary to address the documented goals. The State also requires documentation, signed by the applicant or member that attests to the following:

- The applicant has been given choice of providers.
- The applicant has been given choice of services.
- The proposed IICP is individualized to meet the applicant's needs.
- The applicant has participated in the development of the IICP.
- A copy of the IICP that was submitted with the application was offered to the applicant and/or legal guardian.
- Program requirements, including financial requirements, have been reviewed with the applicant.
- The HCBS Residential Setting Screening Tool (RSST) has been completed with the applicant, a signed copy retained in the clinical record, and the [HCBS member information pamphlet](#) was provided to the applicant.

See [Section 9: Individualized Integrated Care Plan \(IICP\) Development for BPHC Service](#) for additional information regarding person-centered planning and the BPHC IICP requirements and expectations.

DARMHA Data Auto-Populated on BPHC Application

The BPHC application auto-populates with certain data points entered in DARMHA. Consumer demographics cannot be entered into the BPHC application and must be correct in the DARMHA record before completing and submitting an application. Therefore, before submitting the BPHC application packet through DARMHA as described in this section, the BPHC provider agency must review the information entered into DARMHA. If errors are found in the DARMHA data, the errors must be corrected before submitting the BPHC application to ensure accurate information is submitted for review and to prevent an erroneous denial of BPHC eligibility.

Note: Before submitting the BPHC application, all information entered into DARMHA must be reviewed. Any identified errors in DARMHA data must be corrected before submitting the application. The ANSA must also be completed in DARMHA before submission.

The following data points are auto-populated in the BPHC application from DARMHA data:

- DARMHA ID

- Applicant's first and last name
- Date of birth
- Age
- Diagnosis
- Medicaid ID (also referred to as the IHCP Member ID or RID) (if applicable)
- Social Security number
- ANSA completed within 60 days
- ANSA LON

If a BPHC application is initiated in DARMHA and any of the following issues are present, a red "X" will appear on the BPHC application:

- An ANSA has not been completed within 60 days.
- ANSA LON is less than 3.
- The individual is under age 19.
- There is no BPHC-eligible mental health diagnosis.

If the red "X" is generated due to an error in the DARMHA data (for example, the individual is 19 years or older but the date of birth is incorrect in DARMHA), the BPHC provider agency shall update the information in DARMHA before submitting the BPHC application.

Submission of the BPHC Application Packet

Only a DMHA-approved BPHC provider agency may submit a BPHC application. The BPHC application includes a brief assessment of an individual's ability to manage his or her healthcare, a proposed IICP, and supporting documentation. The BPHC provider staff facilitates completion of the BPHC application packet with the applicant through a web-based process. The BPHC application is available through DARMHA and must be completed and submitted in its entirety before the DMHA will render a determination of eligibility for the applicant. The application includes check boxes for attestations that the required documents are attached and the required actions have occurred. Signed attestations and clinical documents must be maintained in the clinical record and available for review by the State as requested. See [Appendix B](#) for an example of the BPHC application.

The following is required for a complete BPHC application submission via DARMHA:

- *Applicant Information:* All applicant demographic information (with the exception of home address, email address, and telephone number) is auto-populated from DARMHA and must be verified and corrected in DARMHA before submitting the BPHC application; the current home address (physical address; a Post Office (P.O.) Box can be listed also if physical address listed) and telephone number must be entered in the BPHC application (This address is where the consumer's BPHC approval or denial notice will be sent. Therefore, it is critical that this information is accurate. Consumers should be asked the preferred address to receive BPHC notices. When the consumer is homeless or does not have an address to provide, the CMHC address can be entered, if the consumer consents).
- *HCBS Waiver:* A consumer must be asked if he or she is participating in any other HCBS waiver or state plan service (as described further in [Section 14: Behavioral and Primary Healthcare Coordination Service](#), BPHC service providers are responsible, in collaboration with waiver providers, for monitoring services of individuals enrolled in a 1915(c) waiver to prevent service duplication)

The BPHC provider must select from the following options:

- Community Integration and Habilitation Waiver
- Family Supports Waiver
- Aged and Disabled Waiver
- Traumatic Brain Injury Waiver
- Money Follows the Person
- Unknown whether consumer is on waiver
(*Note: This option should be selected only if the question has been asked of the applicant, and he or she is uncertain. All BPHC applicants must be asked this question.*)
- Consumer is on a waiver, unsure which waiver
- Not on a waiver

Note: BPHC service providers are responsible, in collaboration with waiver providers, for monitoring services of BPHC members also enrolled in a 1915(c) waiver to prevent service duplication.

- **Current Living Situation:** The radio button next to the applicable current living situation, as described in this section, is entered on the application:

Community-Based Settings

- Homeless: A person is considered homeless if he or she lacks a fixed, regular, and adequate nighttime residence or his or her primary nighttime residence is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations for a period of 3 months or less; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (for example, on the street)
- Private/Independent Home: A “private home” is a residence owned or leased by the member, or a member’s relative, for private personal use
- Non-Provider Owned, Controlled, or Operated (POCO) Residential Setting
- Non-CMHC POCO Residential Setting
- POCO Residential Setting
- Potential Presumed Institutional Setting

Institutional Settings

- Nursing Home: 24 hours a day, 7 days a week care in a skilled nursing facility
- Hospital: 24 hours a day, 7 days a week care in an inpatient psychiatric hospital, psychiatric health facility (such as a stress center), general hospital, private adult psychiatric hospital, Veterans Affairs (VA) hospital, State-operated facility (SOF), or transitional care hospital
- Institution for Mental Disease (IMD): 24 hours a day, 7 days a week care in an IMD
- Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID): 24 hours a day, 7 days a week care in an ICF/IID
- Jail/Correctional Facility: Home detention, detention centers, work release, weekend jail, boot camp, jail, correctional facility, prison

Individuals in institutional settings are not eligible for the BPHC program; however, BPHC applications can be initiated in advance of an individual’s discharge to community-based living as part of the discharge planning process (see [Application to BPHC Pending Discharge from Institutional Setting](#)). (After selecting a radio button from institutional setting under current living situation, information on the anticipated discharge date must be documented. A date box will appear if one of the radio buttons is selected. The discharge date must be in the format of mm/dd/yy.)

- **Eligible Mental Health Diagnosis:** The applicant's eligible primary BPHC diagnosis is selected from the drop-down box; the applicant’s associated symptoms are listed in the box below the drop-down box.

- *Physical Health Issue(s)*: The applicant's current physical health issue(s) for which they need assistance in accessing and/or coordinating care are listed in this section. (In addition, the following examples can be used in place of no medical diagnosis: if the applicant hasn't seen a medical doctor or there is no actual diagnosis but the applicant states his or her believed issues.)
- *Justification of Need for Program*: Information about how the applicant's mental health condition impedes their ability to manage their physical health issue(s) must be documented in this section.
- *Goals*: Information in the applicant's own words stating his or her goal for physical and behavioral stability that promotes movement toward independence and continued community integration must be documented in this section.
- *Objectives*: Information about the necessary steps that the applicant must take to accomplish his or her behavioral and/or physical health goals from the goals section must be documented in this section.
- *Strategies*: Information about how the BPHC service will assist the applicant in meeting their identified goals is listed in this section.
- *BPHC Service Activities*: Providers are to identify the date when the BPHC service (T1016 UC and/or T1016 UC U3) activity was provided during the current eligibility period and a brief description of the service (If BPHC services were not used during the current Individualized Integrated Care Plan (IICP) service package date, the provider must document why the approved service was not utilized by the applicant **and** what the agency will do to engage member into services.) (*Used for provider renewal application only*)
- *Contact Person*: The primary contact and alternate contact at the CMHC for the BPHC application and, if applicable, the individual's legal guardian must be entered on the application. (This information includes the person's name, email address, and telephone number. BPHC clinical denial notifications are sent to both of the agency contact email addresses provided. Any DMHA SET inquiries are also directed to the listed individuals.)
- *BPHC IICP*: The needs statement, goals related to addressing the need for BPHC, BPHC objectives, and strategies are entered on the application. (This information must be focused on helping the individual manage his or her physical and behavioral health needs. The goal(s) on the application should be specific, realistic, measurable, attainable, and in the applicant's own words. BPHC must be one of the strategies, with explicit information on how BPHC will assist in meeting the individual's needs and goals. Any other services that will be used to address the member's behavioral and physical health needs also must be listed as a strategy, along with the purpose of the service. See [Section 9: Individualized Integrated Care Plan \(IICP\) Development for BPHC Service](#) for additional information on the IICP requirements.)
- *Health Questions*: The four health questions must be scored. (See [Section 8: Behavioral Health Assessment Tool \(ANSA\) and BPHC Eligibility](#) for additional information.)
- *BPHC Attestations*: Included in the application is the required acknowledgement that the following attestations have been fulfilled and signed; the date the signatures were obtained by the applicant, legal guardian (if applicable), referring care coordinator, and ANSA SuperUser must be entered on the application; and BPHC provider agencies must maintain the actual documentation with signatures in the clinical record:
 - *Choice of Providers*: Verification that the applicant was informed of his or her right to provider choice, received a randomized list of eligible service providers, and was given the freedom to select the DMHA-approved provider to deliver the BPHC service documented on the proposed IICP
 - *Choice of Services*: Verification that the applicant is choosing to apply for the BPHC service
 - *IICP Development*: Provider or applicant's attestation that the proposed IICP is individualized to meet the applicant's needs and the applicant is requesting the services listed on the proposed IICP

- *Applicant Participation:* Applicant’s attestation verifying his or her participation in the development of the IICP and determination of which behavioral care and healthcare services and/or activities will be included on the plan of care, including the BPHC service
- *Copy of the IICP:* Verification that a copy of the IICP that was submitted with this application was offered to the applicant and/or legal guardian
- *Program Requirements:* Verification that program requirements, including financial eligibility requirements, have been reviewed with the applicant
- *Residential Setting Screening Tool (RSST) and HCBS Pamphlet:* Verification that applicant resides in a HCBS-compliant setting and the [HCBS member information pamphlet](#) was provided to the applicant.

SuperUser Review

An ANSA SuperUser must review and attest to the accuracy and quality of the ANSA associated with each BPHC application.

Saving BPHC Application

While completing the BPHC application, the BPHC provider staff must save the application in DARMHA every 15–20 minutes to prevent information from being lost. Additionally, a BPHC application can be saved as a draft before it is submitted to the SET for completion at a later time. The BPHC provider staff entering the application data must document the assigned IICP number to access the saved application at a later time. The IICP number will also be necessary when addressing any application issues or concerns with the SET or DARMHA Help Desk. A BPHC application left in “Draft” status for more than 60 days will be discarded from the DARMHA system.

Application to BPHC Pending Discharge from Institutional Setting

Individuals in institutional settings are not eligible for the BPHC program. However, BPHC applications can be initiated by the CMHC in advance of an individual’s discharge as part of the discharge planning process. Applications may be submitted to the DMHA no more than 90 days in advance of the individual’s planned discharge. In the *Description of Living Situation* section of the application, information on the discharge, including the anticipated discharge date and the living situation after discharge, must be included. In some settings, such as state-operated facilities (SOFs), Medicaid eligibility would have also been suspended or terminated while the individual was institutionalized.

The DFR must also be contacted through the normal processes to determine Medicaid eligibility. See [Application to BPHC Prior to Member Eligibility Determination](#) for additional information.

Application to BPHC before 19th Birthday

BPHC provider agencies may submit the BPHC application 90 days in advance of an individual’s 19th birthday. Please note that the application will show an “x” next to the age; however, the DMHA team will review the date of birth and determine clinical eligibility for a future effective date of the individual’s 19th birthday if the application is submitted within this time frame.

Additionally, an ANSA is a required component of the BPHC application. CMHCs will need to submit ANSAs for these individuals, as the individuals may have previously had only a Child and Adolescent Needs and Strengths (CANS) assessment completed. CMHCs are encouraged to assist these individuals to initiate the application process with the DFR and Social Security Administration (SSA). Disability determinations can take up to 90 days, so applications for Medicaid and SSA disability determinations should be initiated well in advance of the individual's 19th birthday. See the following section, [Application to BPHC Prior to Member Eligibility Determination](#), for additional information.

Application to BPHC Prior to Member Eligibility Determination

If individuals are not actively enrolled in the IHCP (Indiana Medicaid) when they apply for BPHC, an *IHCP* application must be initiated. As part of the IHCP application process, applicants are required to apply for benefits with the SSA. If individuals already have SSA disability determinations, the State will use this determination for IHCP eligibility purposes. The DFR will review the IHCP application and SSA disability determination to determine an individual's IHCP eligibility, based on factors such as state residency, disability status, income, and citizenship.

In the case of an individual initiating a BPHC application before submitting an IHCP application, the CMHC shall refer the applicant to the DFR application process. Member IHCP applications can be submitted via the methods outlined in the following table. Online submission is the recommended method.

Table 1 – Methods for Applying to the Indiana Health Coverage Programs

Application Method	Instructions
Online (recommended)	<ol style="list-style-type: none"> 1. Go to the DFR website at in.gov/fssa/dfr. 2. Complete and submit application.
By mail or fax	<ol style="list-style-type: none"> 1. Go to the DFR website at in.gov/fssa/dfr. 2. Print paper application. 3. Complete and return application: <ul style="list-style-type: none"> – By mail: P.O. Box 1630; Marion, IN 46952 – By fax: 1-800-403-0864
By telephone	Call the DFR at 1-800-403-0864.
In person at DFR offices	Find the local DFR office at in.gov/fssa/dfr.

The following process applies to individuals who are not actively enrolled in the IHCP when applying for the BPHC with a provider agency:

1. The provider agency completes the ANSA and face-to-face evaluation, including completion of the BPHC application and the proposed IICP, and submits it through DARMHA) for SET review and consideration.
2. The provider agency refers the applicant to the DFR to complete the *Indiana Application for Health Coverage* (IAHC) application and to the SSA for a disability determination.
3. If the SET determines that the applicant does not meet BPHC target group and needs-based eligibility criteria, a clinical denial notice is sent to the provider and the applicant with the clinical denial decision.
4. If the applicant is deemed to meet target group and needs-based eligibility for the BPHC service, the SET notifies the DFR of the approved clinical eligibility.
5. The DFR conducts the IHCP eligibility determination, based on IAHC information and the Social Security Administration (SSA) disability determination.

6. If the applicant does not meet IHCP eligibility, the DFR notifies the DMHA and issues an eligibility denial notice with appeal rights to the applicant.
7. If the DFR determines the applicant eligible for IHCP coverage, the eligibility approval will be viewable in the eligibility verification systems (that is, the IHCP Provider Healthcare Portal [Portal] and Interactive Voice Response [IVR] system); the DFR notifies the DMHA of the approval, and the DFR sends the applicant an eligibility approval notice. (This information is communicated to DXC Technology, which sends the prior authorization letter with approved BPHC units and service package start and end dates to the consumer and provider.)

Note: BPHC service activities provided to an applicant found clinically eligible for the BPHC service are not reimbursable unless a BPHC service authorization is issued and the individual is determined eligible for the IHCP.

An individual will not be eligible to receive the BPHC service until both BPHC clinical eligibility and IHCP eligibility have been established. Following submission of the IHCP application, if an individual who was determined to meet the BPHC clinical criteria is determined IHCP-eligible, the applicant is eligible to receive the BPHC service.

A member's Medicaid eligibility effective date may occur prior to the date BPHC clinical eligibility was determined; however, the BPHC service effective start date is not retroactive and will never be earlier than the date the DMHA SET determined the clinical criteria for the program was met. When an IHCP application is received for a person deemed by the DMHA SET to be BPHC clinically eligible, the DFR begins applying the BPHC financial eligibility rules (that is, income at or below 300% of the FPL) to individuals who are aged, blind, or disabled, beginning the date the DMHA determined clinical eligibility.

Individuals who do not meet the criteria listed in the previous section (the Aged, Blind, or Disabled criteria as determined by DFR) may still be eligible for other IHCP health coverage, such as HIP. See the [Healthy Indiana Plan](http://in.gov/fssa) page at in.gov/fssa.

An individual would have retroactive IHCP coverage only to a date before the BPHC clinical criteria was met if the individual was determined otherwise IHCP-eligible before the BPHC clinical eligibility date. In some cases, IHCP coverage may be retroactive up to 90 days from the date of application, depending on the coverage the member qualifies for and other eligibility criteria. However, BPHC claims billed before the BPHC effective date will be denied.

Example 1: An individual who applied for BPHC and the IHCP is determined to meet BPHC clinical criteria on July 3. The individual does not meet the financial criteria for any other IHCP Aged, Blind, or Disabled aid category and IHCP eligibility is effective July 1. The BPHC service package assignment begins July 3. The BPHC service will not be reimbursed for dates of service prior to July 3.

Example 2: An individual submits an IHCP application and BPHC application July 1. The individual is determined to meet BPHC clinical criteria July 3. When the DFR reviews financial and nonfinancial eligibility, it is determined the individual was otherwise eligible for IHCP coverage the 90 days before the BPHC clinical criteria was met. IHCP coverage will be retroactive to April 1. However, the BPHC service package assignment will still begin on July 3; the BPHC service will not be reimbursed for dates of service prior to July 3. Other IHCP-covered services may be reimbursed for dates of service beginning April 1.

If an individual does not meet non-clinical eligibility criteria as of the date he or she is determined to meet the clinical criteria by the SET, but is determined by the DFR to meet non-clinical criteria as of the following month, the BPHC service package effective date is set for the future date of the DFR determination.

Example: An individual is determined to meet BPHC clinical criteria July 3. The individual does not meet the financial/non-financial criteria for IHCP coverage as of this date. The individual is determined to meet the financial/non-financial criteria as of August 1. IHCP and BPHC eligibility are effective August 1. Reimbursement for BPHC and other IHCP services is not available until August 1.

Providers and enrollees receive notification of BPHC eligibility and service authorization, including the effective date and end date, only after both clinical eligibility and non-clinical eligibility have been established. IHCP applications on the basis of disability are required to be processed within 90 days of submission; all other DFR applications are processed within time lines defined by the specific program the member may be eligible for, such as [HIP](#) or [Hoosier Care Connect](#).

Tracking BPHC Application Status

The status of a BPHC application can be tracked in DARMHA. A full listing of the application status codes is found in [Appendix D: BPHC Application Status Codes](#). The status code is updated whenever a new action is taken on a BPHC application.

Providers are responsible for monitoring the status of each submitted BPHC application to ensure timely processing. Providers must routinely use this code to track where an application is in the process of program eligibility determination to ensure timely processing of each application. Tracking the progress of a BPHC application is an administrative function, not a BPHC service activity.

Section 7: Completing the HCBS Residential Setting Screening Tool

Members who receive services through the Behavioral and Primary Healthcare Coordination (BPHC) program are required to live in a setting that meets federal Centers for Medicare & Medicaid (CMS) requirements for home and community-based services (HCBS) settings (see [Section 4: Home and Community-Based Residence Requirements](#) in this module). To ensure that the residential settings in which applicants for BPHC services live are assessed for compliance with the HCBS Final Rule, the BPHC provider agency, in collaboration with the individual seeking services, must complete the HCBS Residential Setting Screening Tool (RSST) developed by the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and FSSA Division of Mental Health and Addiction (DMHA).

HCBS Residential Setting Screening Tool

The RSST is intended to help members and providers identify the type of *community-based* setting in which a member lives, assess whether that setting meets HCBS criteria, select the appropriate response for the *Current Living Situation* section of the BPHC application in the Data Assessment Registry Mental Health and Addiction (DARMHA), and provide required information about the compliance status of the setting (see [Section 6: Member Application for BPHC](#) in this module). Members who live in an institutional setting are not eligible to receive BPHC services. Institutional settings are defined as the following:

- *Nursing Home*: 24 hours a day, 7 days a week care in a skilled nursing facility
- *Hospital*: 24 hours a day, 7 days a week care in an inpatient psychiatric hospital, psychiatric health facility (such as a stress center), general hospital, private adult psychiatric hospital, Veterans Affairs hospital, State-operated facility (SOF), or transitional care hospital
- *Institution for Mental Disease (IMD)*: Institute for mental disease
- *Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID)*: 24 hours a day, 7 days a week in an ICF/IID
- *Jail/Correctional Facility*: Home detention, detention centers, work release, weekend jail, boot camp, jail, correctional facility, prison

The RSST must be completed during the assessment process for every BPHC application (initial, renewal, or modification) submitted to the DMHA. The RSST must be completed *prior* to creating the BPHC application in DARMHA to ensure that correct information is reported on the BPHC application. A completed copy of the RSST tool, with the member's signature in Section 1, Section 2, or Section 6, must be kept with the member's clinical record, for later review by the DMHA State Evaluation Team (SET).

Accessing and Using the Residential Setting Screening Tool (RSST)

The most current version of the HCBS RSST is available for download from the "HCBS residential setting screening tool (RSST)" link on the [Home- and Community-Based Services](#) page of the DMHA website at in.gov/fssa/dmha (**Mental Health Services > Adult 1915(i) Programs > Home- and Community-Based Services**). Included with the RSST is a companion document that provides general instructions, definitions of terms used in the tool, and additional information for the member and the provider staff completing the tool. Specific instructions and directions are located in each section of the RSST. An example of the RSST form and instructions as well as definitions used in the RSST are located in [Appendix F: Residential Setting Screening Tool](#).

Section 8: Behavioral Health Assessment Tool (ANSA) and BPHC Eligibility

The Adult Needs and Strengths Assessment (ANSA) is the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved behavioral health assessment tool used to identify an applicant's strengths and needs at the time of application, and is used to assist in the identification of an individual's level of need (LON) for the Behavioral and Primary Healthcare Coordination (BPHC) service. The assessment tool consists of items grouped into categories and domains that the provider agency staff will assess and discuss with the applicant. The assessment tool may be used in conjunction with the face-to-face biopsychosocial assessment or in a separate face-to-face session. The combined ratings resulting from the completed ANSA tool generate a LON recommendation that may be used to support a recommendation for the BPHC service.

The LON recommendation from the ANSA tool is not intended to be a mandate for the level of services that an individual may be eligible to receive, but a recommendation that is factored into the final clinical eligibility decision made by the State Evaluation Team (SET). There are many factors, including an individual's preferences and choice that influence the actual intensity of the treatment services recommended on the applicant's proposed Individualized Integrated Care Plan (IICP).

Note: See the following for additional information about the ANSA tool, training, support and certification:

DMHA Telephone: (317) 232-7907

The [ANSA Indiana Manual](http://fssa.in.gov) may be found online at fssa.in.gov.

BPHC Clinical Eligibility and ANSA Ratings

For BPHC clinical eligibility, information in the behavioral health clinical evaluation, referral form, supporting documentation and DMHA-approved behavioral health assessment tool results must substantiate that the applicant meets all the following needs-based criteria:

- Demonstrated needs related to management of his or her behavioral and physical health
- Demonstrated impairment in self-management of physical and behavioral health services
- A health need that requires assistance and support in coordinating behavioral and physical health treatment
- A recommendation for intensive community-based care, based on the uniform DMHA-approved behavioral health assessment tool (ANSA), as indicated by a recommendation of a LON of 3 or higher

Additional Medical and Coordination Indicators

Based on compelling evidence and research indicating there is a significant relationship between mental health and physical health, the DMHA has developed indicators that capture the complexity of an individual's physical health needs. The additional items on the application are considered in determining an individual's need for mental health and physical healthcare service coordination.

The following medical/physical coordination items are included on the BPHC application to evaluate an individual's complexity of healthcare needs in conjunction with mental health needs. The items are used to help determine the individual's need for assistance and support in coordinating mental health and primary healthcare services.

Each item is to be rated using the following guidelines. The item **anchor coding descriptions** are **examples of circumstances** that fit each rating (0, 1, 2, or 3). The descriptions are **not** inclusive. The rater must consider the basic meaning of each rating level to determine the appropriate rating on a dimension (item) for an individual. Additional information related to scoring individual ANSA items may be found in the [ANSA Indiana Manual](#).

Table 2 – Rating Guidelines

Rating	Level of Need
0	No evidence of need
1	Significant history or possible need which is not interfering with functioning
2	Need interferes with functioning
3	Need is dangerous or disabling

Physical/Medical Item: Captures the individual's needs related to management of his or her physical health needs.

Rating	Level of Need
	PHYSICAL/MEDICAL <i>This rating includes both acute or chronic health problems and physical conditions.</i>
0	There is no evidence of physical or medical problems.
1	Mild or well-managed physical or medical problems are indicated. This might include well-managed chronic conditions like diabetes or asthma. A person in need of a physical/medical examination would be rated here.
2	Chronic physical or moderate medical problems are present.
3	Severe, life-threatening physical or medical condition exists.

Medication Management: Captures the individual's needs related to managing medication regimes for prescribed medication.

Rating	Level of Need
	MEDICATION MANAGEMENT <i>This item focuses on the individual's ability to manage his/her prescription medication regimen and the impact on his/her physical and/or mental health symptoms and functioning.</i>
0	There is no evidence that the person has difficulty managing any prescribed medication.
1	Although the individual usually takes medications consistently, he/she may occasionally stop, skip, or forget to take medications without causing instability in the underlying conditions. He/she may benefit from reminders and checks to consistently take medications. OR Individual has significant history of problems managing medication, problems that adversely impacted physical and/or mental health.
2	Over the last year, the person has taken medication inconsistently, had difficulties with side effects, or misuses medications. OR The underlying medical or behavioral health conditions are unstable or adversely affect the individual's functioning. OR The individual makes frequent visits to physician or urgent care center within the last year.
3	Due to the person's inability to self-manage prescribed medications, his/her mental or physical condition is deteriorating and functioning is severely impaired. Inpatient care may be necessary to stabilize the person's condition. OR This level indicates an individual who has refused to take prescribed psychotropic or physical health care medications during the past 180-day period or a person who has abused his or her medications to a significant degree (e.g., overdosing or over using medications to a dangerous degree).

Management of Healthcare: Captures the individual's needs related to understanding and managing physical health needs.

Rating	Level of Need
	MANAGEMENT OF HEALTHCARE: <i>This item focuses on the individual's awareness of co-occurring behavioral and physical health care needs, and individual's ability to manage both.</i>
0	There is no evidence that the person has any co-occurring physical health and mental health conditions nor physical health risk factors (antipsychotic medications, depression, lifestyle risks [smoking, obesity, and inactivity], transportation issues, negative symptoms, or financial barriers to healthcare). He/she recognizes physical and behavioral health issues and risk factors and manages them successfully.
1	The person is aware that he/she requires both physical healthcare and behavioral healthcare, but occasionally has difficulty managing symptoms and health regimens, or making lifestyle changes. Functioning is impaired, such as occasionally missing scheduled appointments; he/she may benefit from reminders and checks to consistently keep appointments and monitor symptoms.
2	The person has moderate difficulty managing physical or behavioral health care. He/she may not consistently follow mental health or physical health care plans or routinely see a primary care physician; may frequently miss scheduled appointments, has interpersonal problems with health care team, or faces barriers to accessing comprehensive, coordinated health care (lack of transportation, long wait for appointments, does not understand treatment plans, is not screened for lifestyle risks), or does not make needed lifestyle changes. OR Side effects and related risk factors for poor physical health are not monitored. OR Individual has visited the emergency room (ER) in the last year.
3	The person is poorly managing his/her healthcare, risking serious or life-threatening complications. He/she may not have a primary health care provider who was seen within the last year. OR Individual uses the ER for primary health care. OR Individual refuses or is unable to participate in either physical or behavioral healthcare, is experiencing an exacerbation of the physical or behavioral health condition, or may be experiencing complications due to multiple health care conditions. OR External barriers prevent the individual from receiving physical and mental health care. OR Individual has been hospitalized within the past year.

Coordination of Healthcare: Captures the individual's needs related to coordination of mental and physical healthcare.

Rating	Level of Need
	COORDINATION OF HEALTHCARE: <i>This item focuses on the need for coordination of physical and mental health for individuals with chronic or acute physical health conditions and behavioral health diagnoses.</i>
0	There is no evidence of a need for coordination of physical and mental health care. Both mental and physical health care are well coordinated and managed by the individual and/or health care team, resulting in stable, healthy functioning.
1	Mild mental and physical health care coordination issues occasionally occur. Such issues are resolved by the individual or health care team.

Rating	Level of Need
2	Moderate need for mental physical care coordination for individual with mental and physical health problems exist. For example, the individual has frequent outpatient or urgent care visits over the past three months in order to stabilize or treat his/her acute or chronic physical condition or behavioral health condition. OR He/she requires support and coordination of medical and behavioral health issues to increase and maintain stability. OR Individual may not be able to communicate across multiple medical/behavioral health providers. OR Physical health care providers may not understand the individual's mental health needs, attribute physical symptoms to psychological issues, not measure and monitor lifestyle risks, or provide vague treatment instructions.
3	Severe care coordination challenges for individual with mental and physical health may result in dangerous or disabling mental or physical health care outcomes or institutional placement. The individual experiences reoccurring problems with limited periods of stability. OR The individual has any ER visits or inpatient hospitalizations within the last year. OR The individual does not have a primary health care provider or has not seen the primary health care provider within the last year. A state hospital or nursing home admission has been considered. External barriers prevent access to physical health care.

Section 9: Individualized Integrated Care Plan (IICP) Development for BPHC Service

Person-centered planning is an existing Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) requirement for all provider agencies in Indiana delivering care to individuals impacted by mental health and/or substance abuse challenges. Further, it is a mandated component with the Centers for Medicare & Medicaid Services (CMS) Home and Community-Based Services ([HCBS final rule](#)) in *Code of Federal Regulations 42 CFR 441.301*.

The following concepts are also required within the individualized treatment planning and service delivery:

- The member has the freedom to choose who is included in the Individualized Integrated Care Plan (IICP) planning and development process.
- The member is an active participant in the IICP planning process, indicating his or her goals and preferences for treatment.
- The member has the right to select the provider agency or individual provider of services, and the right to change individual provider/provider agency during the treatment process.
- The process reflects the cultural considerations of the member and is conducted by providing information in plain language and in a manner that is accessible to members with disabilities and persons with limited English proficiency.

This section outlines the Behavioral and Primary Healthcare Coordination (BPHC) program requirements for development of the IICP during the BPHC member application process and throughout the member's enrollment in the BPHC program.

Staff Requirements

All BPHC IICPs must be developed in collaboration with the applicant (face-to-face) and a DMHA-approved BPHC provider staff meeting the following minimum requirements, as documented in the BPHC rule and State Plan Amendment (SPA) (see [Section 3: BPHC Service Providers](#) for details regarding minimum staffing requirements):

- Licensed professional (LP)
- Qualified behavioral health professional (QBHP)
- Other behavioral health professional (OBHP)

Freedom of Choice

The BPHC member has the freedom of choice regarding the following:

- The desired goals and objectives documented on the proposed IICP
- Inclusion of the BPHC services on the proposed IICP, as supported by the member's documented needs
- The selection of an DMHA-approved providers to deliver the BPHC service

Informed Choice of Providers

During the BPHC application process, the provider agency is responsible for completing and documenting the following activities intended to educate the applicant regarding informed choice of providers:

- Explanation of the applicant's right to an informed choice of providers (meaning the applicant is informed of his or her right to interview potential service providers and make his or her own choice regarding which DMHA-approved BPHC provider agency and service providers will provide the BPHC service documented on the proposed [IICP])
- A list of DMHA-approved BPHC provider agencies within the applicant or member's county of residence and contiguous counties (During the development of the proposed IICP, the agency staff member generates a list of DMHA-approved BPHC agency providers, in randomized sequence of qualified providers, for the applicant to select from when developing the IICP.)
- The applicant is informed that a BPHC provider agency listing is also posted on the [Indiana Health Coverage Programs \(IHCP\) provider website](https://in.gov/medicaid/providers) at in.gov/medicaid/providers; to view the provider listing:
 - Launch the [IHCP Provider Locator](#) tool, accessible from the *IHCP Provider Locator* page at in.gov/medicaid/providers.
 - Under Provider, select the 'Other' radio button and then select Mental Health Provider from the drop-down list.
 - Under Specialty, select Behavioral and Primary Healthcare Coordination (BPHC).
 - Click **Search** to generate a list of providers.
- The applicant is informed of the right to change a BPHC provider or provider agency at any time during enrollment in the BPHC program (The current BPHC provider is expected to assist the member in transitioning service delivery to the newly selected BPHC provider.)
- Obtain the applicant's signature (The BPHC application does not require signed documents by the applicant to be sent to the DMHA; however, the signed documents must be kept in the clinical record and attestation must be made on the application.)

Note: Signed documents are not required with BPHC application submissions through the Data Assessment Registry Mental Health and Addiction (DARMHA). However, the signed documents must be maintained in the clinical record and an attestation must be made on the application.

Person-Centered Plan of Care Development

The IICPs are to be developed with the member driving the care. The member has authority to determine who is included in the process. IICPs require provider staff and member signatures, as well as clinical documentation of member participation. Development of the proposed BPHC IICP must be a collaborative effort that includes the applicant/member, identified community supports, family and nonprofessional caregivers, and the individuals and agency staff involved in assessing and providing care for the applicant/member. The IICP integrates all components and aspects of care that are:

- Clinically indicated and deemed medically necessary
- Supported by the member's identified needs
- Provided in the most appropriate, least restrictive setting to achieve the applicant or member's goals

The provider agency staff must ensure that the IICP development is driven by a *person-centered planning process* that includes the following IICP standards:

- Identifies the applicant or member's physical and mental health support needs, strengths and preferences, and desired outcomes.

- Takes into account the extent of, and need for, any family or other supports for the applicant or member, and neither duplicates nor compels natural supports.
- Prevents the provision of unnecessary or inappropriate care.
- Identifies the BPHC service activities the applicant or member needs and desires for participation.
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes.
- Reflects risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Is clear to the member and individuals who play an important role in supporting the member. The written plan must be in plain language and in a manner that is accessible to individuals with disabilities and persons with limited English proficiency.

The following components must be documented on the IICP:

- Goals that promote stability and potential movement toward independence and continued integration into the community, treatment of physical and mental illness symptoms, and areas of functional deficits related to the illness must be included
- Individuals or teams responsible for treatment, coordination of care, linkage, and referrals to internal or external resources and care providers to meet identified needs should be documented
- The needs statement, goal, objectives, and strategies must be focused on assisting the member in managing his or her health needs
- BPHC must be one of the strategies listed, with an explicit description of how BPHC will assist in meeting the individual's needs and goals
- Any other service that will be used to address mental and physical health needs also must be listed as a strategy, along with the purpose of the service
- All indicated medical and support service coordination needed by the applicant or member to reside in the community, to function at the highest level of independence possible, and to achieve his or her goals should be listed

As part of the completed application, the State also requires documentation, signed by the applicant or member, which attests to the following:

- The applicant has been given choice of providers.
- The applicant has been given choice of services.
- The proposed IICP is individualized to meet the applicant's needs.
- The applicant has participated in the development of the IICP.
- A copy of the IICP that was submitted with the application was offered to the applicant and/or legal guardian.
- Program requirements, including financial requirements, have been reviewed with the applicant.
- The HCBS Residential Setting Screening Tool (RSST) has been completed with the applicant, a signed copy retained in the clinical record, and the [HCBS member information pamphlet](#) was provided to the applicant.

The IICP must be finalized and agreed to, with the informed consent of the applicant or member in writing, and signed by all individuals and providers responsible for IICP implementation. A copy of the IICP must be distributed to the member and other people involved in the plan.

Applicant's Refusal to Sign the IICP

The IICP must reflect the applicant/member's desires and choices for services and supports. The applicant/member's signature, demonstrating his or her participation in the development of the IICP, is required. A signed copy of the IICP must be maintained in the clinical record and an attestation must be included on the electronic application submitted through the Data Assessment Registry Mental Health and Addiction (DARMHA). If an applicant/member requests services but refuses to sign the IICP for various reasons (that is, thought disorder, paranoia, and so on), the provider staff is required to document on the IICP that the member agreed to the IICP, but refused to sign the plan. The provider staff must also document in the clinical record that a planning meeting with the member did occur and that the IICP reflects the member's choice of services and agreement to participate in the services identified in the IICP. The documentation must further explain any known reasons why the applicant/member refused to sign the IICP and how that will be addressed in the future.

Ongoing IICP Review

The provider agency is responsible for ensuring that a member's progress and movement toward attaining the IICP goals is monitored on a regular basis. The provider staff must meet face-to-face with the member at minimum of every 90 days to assess the member's response to service delivery and determine if the member continues to benefit from the BPHC service, and that the IICP continues to meet the member's identified needs, goals, and preferences. Members must be provided with a method to request updates to the IICP, as needed.

Typically, the BPHC service authorization expires within 180 days of the effective authorization date for the BPHC service. However, because the BPHC end date is made to align with the member's Medicaid Rehabilitation Option (MRO) end date, the BPHC service authorization may end sooner than 180 days. The provider agency is responsible for monitoring the expiration of the BPHC service authorization to ensure the timely submission of a renewal application for continued approval of the BPHC service past the effective date of the member's BPHC authorization granted by the DMHA. See [Section 12: BPHC Eligibility Period and Renewal of Eligibility](#) for information pertaining to the renewal of authorization and BPHC eligibility process.

Section 10: SET Determination of BPHC Service Eligibility – Initial BPHC Application

Under the direction of the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and the supervision of the FSSA Office of Medicaid Policy and Planning (OMPP), the State Evaluation Team (SET) is responsible for the determination of Behavioral and Primary Healthcare Coordination (BPHC) *clinical eligibility* and authorization for BPHC service utilization. At initial BPHC application, if the individual is deemed clinically eligible, information is sent to the FSSA Division of Family Resources (DFR), which determines the applicant's BPHC non-clinical eligibility such as income, age, citizenship, and state residency. Applicants must meet both the clinical and non-clinical eligibility criteria to be deemed eligible for the BPHC program.

This section describes the eligibility determination processes for an applicant applying for enrollment in the BPHC program. See [Section 12: BPHC Eligibility Period and Renewal of Eligibility](#) for information on the renewal process.

BPHC Clinical Eligibility Review Process

The BPHC provider agency electronically submits the BPHC application packet to the DMHA SET through the Data Assessment Registry Mental Health and Addiction (DARMHA) system for the State's independent review and assessment of the applicant's clinical eligibility for the BPHC service. Upon receipt of the application, the SET engages in the following activities to determine if the applicant meets *clinical eligibility*:

1. Review the BPHC member application packet for completeness. The following information is required for a complete BPHC application submission via DARMHA. (See [Section 6: Member Application for BPHC](#) for additional information about each of these application fields.) These fields are:
 - a. Applicant Information
 - b. Home and Community-Based Services (HCBS) Waiver
 - c. Current Living Situation (includes Description of the Living Situation)
 - d. Mental Health Condition(s)
 - e. Physical Health Issue(s)
 - f. BPHC Service Activities (during the current eligibility period and benefit to consumer; used for provider renewal application only)
 - g. Contact Person (at the community mental health center [CMHC] and the applicant's legal guardian, if applicable)
 - h. Justification of Need for Program
 - i. BPHC Individualized Integrated Care Plan (IICP) (includes goals, objectives, and strategies)
 - j. Health Questions
 - k. BPHC Attestations

Note: If the DMHA SET pends an application and it is not resubmitted within 7 calendar days from the date it was pended, the application will be denied.

2. Verify that the applicant meets all target group and needs-based BPHC eligibility criteria (see [Section 5: BPHC Member Eligibility Criteria](#) for additional information regarding eligibility criteria).

3. Review the proposed IICP to ensure that the plan meets the following criteria and supports the need for BPHC:
 - a. Goals and objectives are linked to the applicant's identified physical needs for the BPHC program.
 - b. Strategies support the goals, objectives, and needs.
 - c. Evidence is provided that the applicant is able to benefit from the BPHC service.
 - d. Evidence is provided that the IICP submitted is individualized and driven by the applicant's needs and preferences.
 - e. The needs statement section in the IICP supports use of the BPHC service to assist the member in the management and coordination of behavioral and physical healthcare services.
 - f. Any other service that will be used to address mental and physical health needs is also listed as a strategy, as is the purpose of the service.
4. Following review of the application packet and making an evaluation of the member's need for the BPHC service, render one of the following BPHC clinical eligibility determinations:
 - a. *Clinical Eligibility Approved:* If the individual is found clinically eligible, the SET sends the applicant's information to the DFR for review and determination of the applicant meeting BPHC Medicaid financial and other nonclinical Medicaid eligibility criteria. (For additional information, see the following subsections, [Financial and Nonclinical Eligibility Determination](#) and [Authorization of the BPHC Service](#).)
 - b. *Clinical Eligibility Denied:* If the applicant is not clinically eligible for the BPHC program, the DMHA SET notifies the provider and applicant of the clinical denial determination. (See the [Denial of BPHC Clinical Eligibility](#) subsection for additional information.)
 - c. *Clinical Eligibility Pended:* All required fields must be filled out on the BPHC application or it will be denied. If review of the BPHC application determines that the needs-based criteria are met, the applicant lives in a home and community-based setting, and the IICP contains all the required information supporting the need for the BPHC service, but the "Justification for Need of Program," "Consumer's Current Situation," and/or "BPHC Service Activities During the Previous Eligibility Period and Benefit to Consumer" sections of the application lack support, the SET pends the application and requests additional information. The BPHC provider agency shall then review the pended application and the comments provided by the SET in the "Comments" section to correct the application, if appropriate, and resubmit it for final review and eligibility determination. After it is in pending status, the application cannot be put into draft; it must be submitted or the information will be lost. If the SET pends an application and it is not resubmitted within 7 calendar days from the date it was pended, the application will be denied.

Note: The SET may take approximately 10 days to make a determination on clinical eligibility.

Financial and Nonclinical Eligibility Determination

If an applicant is found *clinically eligible* for the BPHC program, the DMHA forwards the clinical approval information to the DFR. If the applicant is already Indiana Health Coverage Programs (IHCP)-eligible when he or she is determined clinically eligible by the SET, the DFR updates the member's existing case.

If the applicant is not IHCP-eligible at the time of BPHC application, as described in further detail in [Section 6: Member Application for BPHC](#), an application to the IHCP is also required. The DFR reviews financial and non-clinical eligibility, such as citizenship and state residency.

1. If the applicant meets the BPHC financial (that is, up to 300% of the FPL for individuals who are Aged, Blind, or Disabled) and nonclinical criteria for IHCP eligibility, the DFR completes the following:
 - a. Notifies the DMHA and CoreMMIS, the State's Medicaid Management Information System, that the applicant meets Medicaid eligibility criteria. (See the following [Authorization of the BPHC Service](#) subsection for additional information.)

Note: Income criteria: To be eligible for BPHC, an individual who is aged, blind, or disabled must have income at or below 300% of the federal poverty level (FPL). The DFR makes the final financial eligibility determination.

- b. Sends eligibility notice to the applicant, notifying him or her that he or she is eligible for IHCP coverage.
2. If the applicant does not meet criteria for IHCP eligibility, the DFR completes the following:
 - a. The DFR notifies the DMHA that the applicant is not IHCP-eligible (See the following [Denial of BPHC Eligibility](#) subsection for additional information.)
 - b. The DFR sends an IHCP denial notice to the applicant (Providers can verify an individual's IHCP eligibility status through normal IHCP eligibility verification methods, as detailed in [Member Eligibility and Benefit Coverage](#) module located at in.gov/medicaid/providers.)

Note: The DFR has up to 90 days to make a determination of IHCP eligibility on the basis of disability.

Authorization of the BPHC Service

Final eligibility for the BPHC program is based on the applicant meeting clinical, nonclinical (for example, residency and citizenship), and financial criteria. After the DMHA receives notice from the DFR that an individual is eligible and enrolled in the IHCP, the following occurs, enabling the applicant to begin utilizing the BPHC service:

1. The SET transmits the BPHC program and service approval to the IHCP
2. This approval is entered into the IHCP Provider Healthcare Portal (Portal), and a BPHC approval notice is sent to the applicant and his or her provider. The authorization notification generated includes the following information:
 - a. Start and end dates for BPHC eligibility (See [Section 11: BPHC and IHCP Services Eligibility and Authorization](#) for additional information.)
 - b. BPHC procedure code, modifiers, and number of units approved

Denial of BPHC Eligibility

An applicant may be determined ineligible for BPHC due to not meeting clinical criteria (as determined by the SET) or financial and other non-clinical criteria (as determined by the DFR). If the applicant is determined ineligible (denied the BPHC service), the following occurs:

1. If an applicant is determined *clinically* ineligible for the BPHC program by the DMHA (SET, the DMHA sends a denial notification with appeal rights to the applicant and provider, informing them that their application for the BPHC service has been denied. If applicable, the BPHC provider agency shall notify the applicant's authorized representative of the denial if the

authorized representative is listed in the contacts section of the application. The notice includes the reason for denial and information about appeal rights and how to appeal the determination.

2. Individuals applying to BPHC who are found ineligible for the IHCP for reasons other than a clinical denial (for example, their income exceeds 300% of the FPL, they do not meet State residency requirements, and so on) receive an IHCP eligibility denial or discontinuance notice from the DFR. This notice includes information about appeal rights and how to file an appeal for the denial determination.

BPHC Eligibility and Authorization Effective Dates

Information regarding the BPHC eligibility determination and approval for utilization of the BPHC service may be accessed by providers on the [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers.

BPHC service delivery may not begin until an individual has Medicaid eligibility determined and clinical eligibility is approved by the SET. BPHC provider agencies do not receive reimbursement for providing BPHC service before SET and DFR approval, or for delivery of the service outside the BPHC eligibility period documented on the authorization notification.

The BPHC service package assignment effective date is based on the following rules:

- The earliest effective date for BPHC eligibility is the program effective date of June 1, 2014.
- The BPHC effective date is never earlier than the date the SET determined clinical criteria was met.
- The BPHC effective date can be any day of the month.
- If an individual does not meet the IHCP nonclinical or BPHC Medicaid financial criteria as of the date the SET determines clinical criteria was met (for example, the applicant's income exceeds 300% of the FPL, the applicant is not a resident of Indiana, and so on), the BPHC effective date is the date the DFR determines the member met BPHC nonclinical and financial criteria. This date is never earlier than the date the SET determined clinical criteria was met (see [Section 6: Member Application for BPHC](#) for additional information).

Applicant's Discharge before BPHC Eligibility Determination

If an application needs to be withdrawn or discharged before the DMHA SET makes a clinical determination, the BPHC provider shall notify DARMHA via secure email to darmha@fssa.in.gov. This directive applies in cases when the applicant moved out of Indiana, died before completing the clinical eligibility determination, and so on. This email must include the following:

- Applicant's name
- IHCP number
- The reason the application should be discharged (for example, indication that the applicant has died)
- Date

Section 11: BPHC and IHCP Services Eligibility and Authorization

The Behavioral and Primary Healthcare Coordination (BPHC) member is eligible to receive all medically necessary Medicaid services – for example, Medicaid outpatient mental health services, Medicaid Rehabilitation Option (MRO), and/or Adult Mental Health Habilitation (AMHH) services – for which the member qualifies. This section provides basic information regarding authorization for Medicaid behavioral health services that supplement the BPHC service. For members who are not otherwise Medicaid-eligible, either through Healthy Indiana Plan (HIP), Hoosier Care Connect, or Traditional Medicaid (Indiana Health Coverage Programs [IHCP]) (that is, they are eligible for Medicaid only through the Aged, Blind, or Disabled category because of their eligibility for BPHC), the BPHC service eligibility and service authorization must be obtained for the BPHC member to access and use other Medicaid services. For these members, a lapse in BPHC eligibility may result in the loss of coverage.

BPHC and MRO Service Authorization

The following applies for members using MRO in conjunction with the BPHC service:

- For members who have an active MRO service package assignment at the time of BPHC application, the BPHC program eligibility end date is aligned with the current MRO end date; so, moving forward, the two application processes will be aligned. The number of BPHC units authorized is prorated based on the time left until the MRO service package expires, as outlined in the following table.

Table 3 – BPHC Units Authorized with Active MRO Service Package

# Months Until MRO Expires	# Units of BPHC Authorized
6	48
5	40
4	32
3	24
2	16
1	8

- For example, if a member is determined eligible for BPHC as of September 1, 2017, and the MRO service package expiration date is October 12, 2017, 16 BPHC units would be approved, and the BPHC expiration date will be October 12, 2017.
- When BPHC and MRO service package authorizations are aligned following the initial application and authorization process described previously, the BPHC service is approved for 48 units. The MRO Case Management Services (billing code T1016 HW) is authorized at 48 fewer units of service than would be authorized if the member was not utilizing the BPHC service. See [Section 12: BPHC Eligibility Period and Renewal of Eligibility](#) for additional information on the BPHC renewal process.
- For members who are not IHCP-eligible at the time of BPHC application and, therefore, do not have an active MRO service package assignment, the MRO service package is aligned with the BPHC effective and end dates (see [Section 10: SET Determination of BPHC Service Eligibility –Initial BPHC Application](#) for further information on how the BPHC effective date is set). Forty-eight units of BPHC are authorized, and the MRO service package is assigned based on the member's level of

need (LON), as outlined in the [Medicaid Rehabilitation Option Services](#) module, with the exception that the number of authorized MRO case management units (T1016 HW) are reduced by 48 units, as outlined in the following table.

Table 4 – MRO Case Management Units Authorized with Active BPHC

MRO Service Package	# Authorized MRO CM Units
3	152
4	252
5	352
5A	452

BPHC and AMHH Service Authorization

The following applies for members using AMHH in conjunction with BPHC:

- For members who have active AMHH service package assignments at the time of BPHC application, the number of BPHC units is authorized based on the time left until the AMHH evaluation is due, as outlined in the following table. If the AMHH end date is in less than 180 days, the BPHC end date is aligned with the AMHH end date. If the AMHH end date is more than 180 days away, the BPHC service is authorized for a 180-day period. In both scenarios, the active AMHH authorization period remains unchanged.

Table 5 – BPHC Units Authorized with Active AMHH

# Months Until AMHH Expires	# Units of BPHC Authorized
6-12	48
5	40
4	32
3	24
2	16
1	8

- If a member applies for AMHH after he or she already has an active BPHC service package assignment, the number of authorized AMHH Care Coordination units (billing code T1016 UB) is reduced to account for the BPHC service package assignment. The AMHH approval end date is aligned with the existing BPHC approval period.

Lapses in IHCP Coverage – Impact on Service Authorization

In accordance with federal regulations, IHCP eligibility must be reviewed at least every 12 months through the Family and Social Services Administration (FSSA) Division of Family Resources (DFR). The IHCP eligibility redetermination process is established by the DFR and is not on the same schedule as BPHC renewals. Because a member must be IHCP-eligible to be BPHC-eligible, if the member loses IHCP eligibility, the BPHC service is not reimbursed during the lapse in IHCP eligibility. However, as long as (MRO or AMHH and BPHC clinical eligibility is retained, the BPHC, AMHH, and MRO packages remain

in place. Therefore, if the member reestablishes IHCP eligibility, and the BPHC/MRO or BPHC/AMHH service authorization hasn't lapsed, the member may restart services without having to reapply for AMHH or BPHC service authorization. However, if the BPHC, AMHH, or MRO authorization or service package has lapsed, a new BPHC application is required to assess eligibility for the BPHC program.

Section 12: BPHC Eligibility Period and Renewal of Eligibility

A member who is approved to receive Behavioral and Primary Healthcare Coordination (BPHC) is eligible for BPHC services for up to 180 days from the date of service approval and authorization. As described in further detail in [Section 11: BPHC and IHCP Services Eligibility and Authorization](#), when a member has an active Medicaid Rehabilitation Option (MRO) service package assignment at the time of BPHC authorization, the MRO and BPHC clinical eligibility expiration dates are aligned so the BPHC renewal occurs at the same time as the MRO service package expiration date. In all other cases, BPHC must be renewed every 180 days. To prevent a gap in coverage, the provider agency is responsible for tracking the end date of the BPHC service and submitting a BPHC eligibility renewal application.

BPHC Renewal Process

Note: The care coordinator, the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved BPHC provider overseeing the member's BPHC service delivery, is responsible for assisting the member in tracking authorization end dates and facilitating initiation of the renewal process.

The provider agency is responsible for tracking the end date of BPHC and submitting a renewal application, including an updated proposed Individualized Integrated Care Plan (IICP) and Adult Needs and Strengths Assessment (ANSA) at least 30 calendar days (but no more than 60 calendar days) before the end of the BPHC service period. A report is available in the Data Assessment Registry Mental Health and Addiction (DARMHA) to assist providers in tracking the BPHC end date (see [Appendix E](#)). Service package end dates for MRO and BPHC are aligned (when applicable) so that renewals occur at the same time for both programs. To prevent a potential gap in eligibility for Indiana Health Coverage Programs (IHCP), BPHC applications must be submitted in DARMHA at least 30 calendar days (but no more than 60 calendar days) before the BPHC eligibility end date.

A BPHC reevaluation follows the same eligibility determination processes as the initial BPHC application, as described in previous sections. Failure to submit the BPHC renewal application within the designated time frame and before the end date of the BPHC eligibility period may result in a lapse of authorization for the member, including loss of IHCP eligibility for members who are only IHCP-eligible because of BPHC eligibility. If IHCP eligibility is not reestablished, the lapse in authorization results in a denial of reimbursement for any BPHC service provided during the lapse in authorization. The following BPHC renewal process applies for all BPHC members:

1. The BPHC renewal application must be submitted into DARMHA at least 30 calendar days (but no more than 60 calendar days) before the BPHC clinical eligibility end date to ensure adequate time for processing the application. Failure to submit a BPHC renewal application at least 30 calendar days in advance may result in a gap in coverage. Submission of the BPHC renewal packet requires the following:
 - a. Conducting a face-to-face holistic clinical and biopsychosocial evaluation completed by a DMHA-approved BPHC service provider.
 - b. Administration of the ANSA within 60 days of the BPHC application submission to determine whether the member meets the level of need (LON) for intensive community-based services, as demonstrated by a rating level of three or higher.
 - c. Assessment of the member's progress toward meeting treatment goals on the BPHC IICP. A review of how the member has benefited from the BPHC service and the BPHC service activities utilized during the current eligibility period are components of the clinical renewal determination. The assessment must be summarized appropriately in the designated field on the renewal application.

- d. Confirming, via any submitted documentation, that the member continues to meet BPHC target group and needs-based eligibility criteria.
 - e. Completing an updated BPHC application, including all attestations with signatures maintained in the clinical record.
 - f. Completing an updated IICP documenting the member's choice of BPHC service providers.
2. The State Evaluation Team (SET) reviews and assesses the application and the member's response and needs based on the clinical reevaluation information submitted to determine whether the member continues to meet BPHC eligibility criteria and needs-based eligibility criteria.
3. If determined clinically eligible for BPHC during the renewal process, the applicant and the referring provider agency receive a service authorization notice. The provider agency is responsible for notifying the member's legal guardian or authorized representative (if applicable).
4. If the member is determined by the SET to no longer be clinically eligible for BPHC, the member and provider receive a denial notification with appeal rights from the DMHA (including the member's appeal rights). The DMHA notifies the Division of Family Resources (DFR) of the change in BPHC clinical eligibility. The DFR determines if the consumer is eligible for an alternate IHCP eligibility category. If the loss of BPHC clinical eligibility results in loss of IHCP eligibility (that is, the member was only IHCP-eligible due to meeting the BPHC needs-based and targeting criteria, and the BPHC income eligibility of under 300% of the federal poverty level, or FPL), the DFR sends a discontinuance notice with appeal rights to the member and authorized representative.

All BPHC renewals are handled as addressed in this section, with the exception of BPHC applications approved within 60 days of the MRO end date.

When a BPHC applicant has an active MRO service package assignment, the BPHC end date is aligned with the MRO end date. The DMHA SET reviews and facilitates a renewal determination of BPHC eligibility based on the original application, without the need for a community mental health center (CMHC) to submit a new application.

Note: Though no one is prohibited from applying for BPHC, members who are already IHCP-eligible and receiving MRO do not receive additional benefits by applying for BPHC. Therefore, the need for a BPHC application should be carefully evaluated in this situation.

Administrative Renewals

When an initial BPHC application is submitted for a member that has an MRO service package expiring within 60 days of the start date of the initial BPHC package, the CMHC is not required to submit a renewal application. The DMHA SET reviews and facilitates a renewal determination ("Administrative Renewal") of BPHC eligibility based on the original application without the need for a CMHC to submit a new application. BPHC and MRO have the same end date going forward for each 6-month eligibility period. A BPHC renewal application must be submitted at least 30 days (but no more than 60 days) before the end date of BPHC and MRO going forward.

A Loss or Interruption of BPHC Service

When there is an interruption in BPHC service delivery due to the member leaving the community and entering an institutional setting (for example, incarceration, hospitalization, state-operated facility [SOF], and so on), the BPHC service may not be billed during the period of service interruption. The BPHC eligibility and authorized service units remain available to the member, within the originally authorized BPHC eligibility period, for access when the member returns to the community. If however, the member does not return to the community during the BPHC eligibility period, the member must reapply for BPHC service, via a new BPHC application, before or at reintegration into the community, with the assistance of a BPHC service provider agency. If there is a loss of IHCP eligibility, a new *Indiana Application for Health Coverage* (IAHC) must also be submitted, as described in the [Application to BPHC Prior to Medicaid Eligibility Determination](#) subsection in *Section 6*.

Termination of BPHC Program

If the BPHC service needs to be terminated before the end of the BPHC eligibility period (for example, a member requests to terminate the service), the provider agency must assist in linking the member to services or programs that may be able to meet the individual's needs. The provider agency must document in the clinical record the efforts made to coordinate transition to other services or benefits. If a provider is no longer serving a consumer, the provider agency must follow the required practice of closing the DARMHA episode. In addition, it is the provider's responsibility to complete a discharge ANSA if required. For example, if a client dies or drops out of treatment, a discharge ANSA is not required. However, the service episode must be closed in DARMHA.

Section 13: Clinical and Administrative Documentation

The Behavioral and Primary Healthcare Coordination (BPHC) provider agency must comply with all clinical documentation requirements as defined by the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) or Office of Medicaid Policy and Planning (OMPP) as well as the Centers for Medicare & Medicaid Services (CMS). To be reimbursable, the BPHC service and program eligibility must be supported by documentation that is maintained in the member's clinical record.

The documentation required to support billing for BPHC service activities must meet the following standards:

- Reflect progress toward the goals documented in the member's Individualized Integrated Care Plan (IICP).
- Be updated with every member encounter when billing is submitted for reimbursement.
- Be written and signed by the provider staff rendering services.

The documentation to support billing for the BPHC service must:

- Focus on recovery and habilitation and/or rehabilitation.
- Support coordination and/or management of identified health needs and services.
- Emphasize consumer strengths.

General Documentation Requirements

Note: A provider must maintain documentation for services provided to a BPHC service member in accordance with the requirements under Indiana Administrative Code 405 IAC 5-21.8-6.

Providers are responsible for understanding and adhering to the requirements and limitations for the BPHC activities the providers are qualified to provide. Questions about a BPHC activity and its requirements may be directed to the State Evaluation Team (SET). This team is responsible for completing BPHC quality assurance (QA) activities in support of CMS requirements for the delivery of the BPHC service. The following applies to each BPHC service activity that is billed for reimbursement:

- All BPHC service and eligibility documentation is subject to review by the CMS and the State, or its designees.
- The provider is subject to denial of payment or recoupment for paid claims for services if the provider does not have adequate documentation to support the BPHC service activity billed.
- Clinical documentation of service activities under this section, including face-to-face service activities and services on behalf of the member, must contain the following information:
 - Date of service rendered, including month, day, and year
 - Start and end time of the service
 - Actual time spent rendering the service (*Note: The content of the documentation must support the amount of time billed. See [Section 18: BPHC Service Billing](#), for additional information about calculating time spent providing BPHC service.*)
 - Location or setting where the service activity was provided
 - Member's IICP goal being addressed during the session with a focus on physical and behavioral health management

- Type of service activity being provide
 - Focus of the session or service activity delivered to or on behalf of the member
 - Strengths of client
 - Member’s symptoms, needs, goals, or issues addressed during the session
 - Progress made toward meeting goals noted on the IICP with a focus on health management
 - Names and qualifications of the staff providing the service (*Note: BPHC progress notes MUST include the staff qualifications such as: Qualified Behavioral Health Professional [QBHP] or Other Behavioral Health Practitioner [OBHP].*)
- Additional documentation is required for each service activity provided on behalf of a member that is not present. This documentation includes:
 - Names of all persons attending the session and each person’s relationship to the member
 - How the service benefits the member and assists the member in reaching the IICP goals

BPHC Member Home and Community-Based Settings Requirements

BPHC is a home and community-based services (HCBS) program. In accordance with federal regulations for 1915(i) State Plan HCBS programs, service activities are to be provided within the individual’s home (place of residence) or at other locations based in the community. Service activities cannot not be provided in an institutional setting.

In January 2014, the CMS published regulations to better define the settings in which states can provide Medicaid HCBS. The HCBS Final Rule became effective March 17, 2014. The HCBS Final Rule, along with additional guidance and fact sheets, is available on the CMS Home and Community Based Services site.

To view the HCBS statewide transition plan, go to the [Home and Community-Based Services Final Rule Statewide Transition Plan](#) page at [in.gov/fssa](#).

Section 14: Behavioral and Primary Healthcare Coordination Service

The Behavioral and Primary Healthcare Coordination (BPHC) program consists of one service that comprises a variety of reimbursable activities intended to assist in the coordination of mental health and primary healthcare services to manage the healthcare needs of the BPHC member. Service activities include logistical support, advocacy, and education to assist individuals in navigating the healthcare system, and activities that help members gain access to needed mental health and physical health services and manage their health conditions. These services include the following:

- Coordination of healthcare services, which may include:
 - Direct assistance in gaining access to services
 - Coordination of care within and across systems
 - Oversight of the entire case
 - Linkage to services
- Assistance in using the healthcare system, which may include:
 - Logistical support
 - Advocacy
 - Education
 - Referral and linkage to medical providers
- Coordination of services across systems, which may include:
 - Physician consults, defined as facilitating linkage and communication between medical providers
 - Serving as a communication conduit
 - Notification of changes in medication regimens and health status
 - Coaching for more effective communication with providers

Service Delivery

The following activities may be provided under the BPHC service:

- *Needs Assessment:* A needs assessment consists of identifying the member's needs for coordination of health services, including reassessments. Specific assessment activities necessary for a complete needs assessment of the member may include:
 - Gathering information about the member's history
 - Identifying the member's needs
 - Completing related documentation
 - Gathering information from other sources, such as:
 - Family members
 - Medical providers
- *IICP Development:* These activities include the development of a written Individualized Integrated Care Plan (IICP), based on the information collected through the needs assessment phase. The IICP shall include member-driven goals for healthcare or lifestyle changes, and identify the health activities and assistance needed to accomplish the member's objectives. IICPs may include activities and goals such as:
 - Referrals to medical services
 - Education on health conditions

- Activities to ensure compliance with health regimens and healthcare provider recommendations
- Activities or contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the health needs of the individual
- *Referral and Linkage*: This activity includes helping link the member with medical providers and other programs and services that are capable of providing needed health services
- *Coordination of Healthcare Services*: These activities provide coordination of health services across systems, including but not limited to:
 - Physician consults, defined as facilitating linkage and communication between medical providers
 - Provider serving as a communication conduit between the member and specialty medical and behavioral health providers
 - Notification, with the member's permission, of changes in medication regimens and health status
 - Coaching to assist the member in interacting more effectively with behavioral and primary healthcare providers
- *Monitoring and Follow-up*: These activities include face-to-face contact with the member at least every 90 days, including:
 - Contacts and activities necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the member
 - Activities and contacts with the following individuals:
 - The member
 - Family members or others who have a significant relationship with the member
 - Nonprofessional caregivers
 - Providers
 - Other entities
- *Evaluation*: These activities include periodic reevaluation of the member's progress for the following reasons:
 - To ensure that the IICP is effectively implemented and adequately addresses the member's needs
 - To determine if the services are consistent with the IICP and if any changes to the IICP are required
 - To make changes or adjustments to the IICP to meet the member's ongoing needs
 - To evaluate or reevaluate the member's progress toward achieving the IICP's objectives

Programming Standards

All BPHC service activities provided to a member must meet the following requirements:

- Be supported by the member's level of need (LON)
- Be documented in the member's plan of care, in accordance with the requirements under *Indiana Administrative Code 405 IAC 1-5-1*

Provider reimbursement for the BPHC service is subject to, but not limited to, the following:

- The member's eligibility for the service
- The provider staff's qualifications and certification
- The scope, limitations, and exclusions of the service activity

Billing for Clinical Supervision of BPHC Service Activities

The time devoted to formal supervision between the BPHC provider staff and the licensed supervisor to review the member's care and treatment shall:

- Be an included BPHC activity
- Be documented accordingly in the member's clinical record
- Be billed under only one provider staff

Exclusions

The following activities are not reimbursable as BPHC services:

- Activities billed under Behavioral Health Level of Need (LON) Redetermination
- Activities billed under Medicaid Rehabilitation Option (MRO) Case Management
- Activities billed under Adult Mental Health Habilitation (AMHH) Care Coordination
- An activity provided as a diversion, leisure, or recreational activity
- The actual or direct provision of medical services or treatment, including but not limited to medical screening, such as blood pressure screenings or weight checks
- Activities billed under medication training and support
- Individual, group, or family therapy services
- Activities billed under crisis intervention services
- Services provided to the member at the same time as another service that is the same in nature and scope, regardless of funding and provider source. This includes, but is not limited to, Home and Community-Based Services (HCBS) waivers, as described in the [1915\(c\) Home and Community-Based Service \(HCBS\) Waivers](#) subsection
- Services provided while the member is in an institutional or non-community-based setting
- Services provided in a manner that is not within the scope or limitations of a BPHC service activity
- Service activities not documented as covered or approved on the member's Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved IICP
- Service activities not supported by documentation in the member's clinical record
- Service provided exceeding the defined limits of the service, including service quantity, limits, duration or frequency
- Activities excluded from the service scope or definition

HCPCS

The following table outlines the Healthcare Common Procedure Coding System (HCPCS) codes for BPHC. Tier 1 providers include licensed professionals (LPs), qualified behavioral health professionals (QBHPs), and other behavioral health professionals (OBHPs). Tier 2 providers include DMHA certified recovery specialists (CRSs) and community health workers (CHWs).

Table 6 – HCPCS Codes for Behavioral and Primary Healthcare Service

Code	Modifiers	Code Description
T1016	UC – Case Management for BPHC	Case management, each 15 minutes; Behavioral and Primary Healthcare Coordination, each 15 minutes BPHC- Tier 1: 1 Unit = 15 minutes \$14.53 per 15 minute unit Limited to 48 units (12 hours) per 6 months total units in combination with T1016 UC U3
T1016	UC U3 – Case Management for BPHC	Case management, each 15 minutes; Behavioral and Primary Healthcare Coordination, each 15 minutes; Community Health Worker and/or Certified Recovery Specialist BPHC- Tier 2: 1 Unit = per 15 minutes \$8.55 per 15 minute unit; Limited to 48 units (12 hours) per 6 months in combination with T1016 UC

Limitations

The BPHC service is limited to a maximum of 12 hours, or 48 units, per 6 months.

1915(c) Home and Community-Based Services (HCBS) Waivers

A BPHC consumer may receive 1915(c) waiver services. However, a federally approved HCBS benefit requires that services not duplicate other Medicaid funded services that are already available. Service duplication would most likely occur in the following four areas, which are available through the following HCBS benefit programs or other Medicaid funded programs:

- Community Integration and Habilitation (CIH) Waiver:
 - Case management
 - Wellness coordination
- Family Supports Waiver (FSW):
 - Case management
- Aged and Disabled (A&D) Waiver:
 - Healthcare Coordination
- Traumatic Brain Injury (TBI) Waiver
- Managed care providers:
 - Care coordination

BPHC care coordinators, must ensure person centered planning, and that all services, regardless of funding sources, are included in the members IICP. When a member has an HCBS waiver, the HCBS waiver case managers and BPHC care coordinator are responsible for monitoring services to prevent duplication. The BPHC provider staff must coordinate the provision of BPHC service activities with the waiver case manager. BPHC provider agencies must have written policies and procedures to ensure communication and collaboration with waiver case management and wellness coordination providers. All communications and

interactions with HCBS waiver providers must be documented in the clinical record. To avoid duplication of services, BPHC provider staff must develop and document a detailed description of BPHC and HCBS waiver services such as case management, healthcare coordination, or wellness coordination activities the applicant or member is receiving. BPHC provider staff must document attempts to coordinate with the HCBS waiver provider. This service overview must clearly define both HCBS waiver and BPHC provider staff roles and responsibilities, and specific goals in the member's IICP that the services are addressing.

Utilization of HCBS Benefit

Participation in HCBS is determined through claim activities specific to BPHC as well as BPHC provider case notes. According to the Centers for Medicare & Medicaid Services (CMS), to be deemed a current, actively enrolled participant within the BPHC benefit, BPHC-enrolled members with BPHC service authorization must have at least one unit of BPHC service billed for a date of service within the 180-day BPHC eligibility period. For each BPHC-delivered service activity, there must be clear documentation in the case notes that support how the authorized BPHC service activity was used to support the member during the plan period. If a member has not utilized the BPHC benefit during the plan period, there must be clear documentation of all efforts to engage the member and reason why no authorized BPHC services were delivered during the eligibility period.

Section 15: Quality Assurance and Performance Measures

Overview of Activities

Provision of the Behavioral and Primary Healthcare Coordination (BPHC) service is dictated by service scope and limitations of the service, as outlined in the Centers for Medicare & Medicaid Services (CMS)-approved BPHC Service State Plan Amendment (SPA) and supported by *Indiana Administrative Code 405 IAC 5-21.8* (Indiana rule for administration of the BPHC service), as well as the needs of the member documented in the BPHC evaluation and the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA)-approved Individualized Integrated Care Plan (IICP). The DMHA and FSSA Office of Medicaid Policy and Planning (OMPP) hold the BPHC provider agencies accountable for following all BPHC and Medicaid policies, regulations, and standards, and monitor provider agencies for compliance with those standards through the following methods:

- *Medicaid Management Information System (MMIS) Data Audits:* Audits of electronic BPHC service data, which includes data on referrals, IICPs, and service utilization (in the form of claims). To ensure provider agency compliance with the BPHC program and the DMHA's expectations of the agency as a BPHC provider, site reviews are completed for each provider agency at least annually.
- *On-Site Reviews:* The DMHA conducts on-site reviews with the provider agencies on a regularly scheduled cycle, or as needed based on indicators of service delivery issues, such as complaints or serious events. The DMHA reviews a sample of the provider agency's client records, including case notes, IICPs, and documentation of serious events. The DMHA conducts a review of the agency's policies and business processes relating to the BPHC member's freedom of choice, the member's right to lodge grievances and complaints, and provider agency compliance with BPHC standards and expectations.
- *Collection of Performance Measure Data:* The BPHC service-related data collected or requested from provider agencies supports performance measures used to monitor and assure compliance with BPHC quality standards, as noted in the 1915(i) SPA. Performance measure activities include analysis of claims data, review of all IICPs, provider site visits, and tracking and monitoring incident reports.
- *Incidents and Complaints:* The DMHA monitors incidents, member complaints, and administrative reviews related to the BPHC service. The DMHA staff review the data on a regular basis to identify trends or issues that may require training, policy clarification, process improvement, or other follow-up. The data is maintained and summarized quarterly.

Quality improvement (QI) data collected is concurrent with the Quality Improvement Measures outlined in the BPHC SPA. Utilization data and results of site visits are compiled and maintained for the DMHA and the OMPP review. Quality assurance (QA) data is collected and reviewed quarterly. Findings from site reviews are used for necessary individual agency corrective action, as well as training and education for all provider agencies.

Corrective Action

The DMHA issues corrective actions against any provider agency failing to follow BPHC policies, standards, and regulations. Failure on the part of the agency to respond to a corrective action imposed by the DMHA by the date prescribed in the review findings report may result in additional corrective action, such as denying service claims or revoking approval of the provider as a BPHC provider agency. The Corrective Action Plan (CAP) is monitored by the DMHA and the OMPP to assure correction occurs and that remediation is effective in addressing any issues identified. The DMHA conducts follow-up reviews

when significant issues have been discovered; a pattern of complaints regarding the BPHC service is provided; or no progress is made on remediation actions identified in the CAP.

Section 16: Fair Hearings and Appeals

The Family and Social Services Administration (FSSA) Office of Hearings and Appeals (OHA) is an administrative section in the FSSA that receives and processes appeals from people receiving services in FSSA programs, including Behavioral and Primary Healthcare Coordination (BPHC) and many other programs. Administrative hearings are held throughout the state of Indiana, usually at county FSSA Division of Family Resources (DFR) locations, at which time all parties have the opportunity to present their cases to an administrative law judge (ALJ).

Appeal and Fair Hearing Rights

Notices of action (NOAs) sent to an applicant or member provide an explanation of the decision made on an application for services or a change in services. When an individual disagrees with the decision, he or she has the right to appeal by submitting a request for a fair hearing.

Requesting an Appeal

Any of the following individuals may appeal an adverse agency action by the FSSA Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET) and request an administrative hearing:

- An applicant
- A member of BPHC
- A duly authorized representative of an applicant or a member

An authorized representative (AR), applicant, or member appealing an action under this rule must follow the appeal processes and procedures in *Indiana Administrative Code 405 IAC 1.1*. Administrative hearings and appeals by an applicant or member are governed by the procedures, time limits, provisions, and requirements set forth in *405 IAC 1.1*.

Appeals must be received by close of business not later than:

- Thirty-three calendar days following the effective date of the action being appealed
- Thirty-three calendar days from the date of the notice of agency action, whichever is later

To file an appeal, a signed and dated appeal form must be sent to:

MS04
Indiana Family and Social Services Administration
Office of Hearings and Appeals
402 W. Washington St., Room W392
Indianapolis, IN 46204
Fax: (317) 232-4412

Section 17: Grievances and Complaints

Any of the following individuals shall have the right to file a written complaint or a written grievance with the State, the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) or the FSSA Office of Medicaid Policy and Planning (OMPP):

- An applicant
- A member of the Behavioral and Primary Healthcare Coordination (BPHC) service
- Duly authorized representatives of an applicant or a member

Upon receipt of a complaint or a grievance, the DMHA shall:

1. Log the complaint or grievance
2. Initiate an investigation

The DMHA's decision with regard to a complaint or a grievance may not be appealed. The filing of a complaint or grievance is not a prerequisite to filing an appeal under [Section 16: Fair Hearings and Appeals](#).

If the DMHA sends a letter to a provider agency under this section stating its findings regarding a complaint or a grievance of an applicant or a member, the following shall apply:

- The DMHA may require the provider agency to correct an identified deficiency within a time line established by the DMHA.
- A provider agency's failure to correct the deficiency within the established time line may result in sanctions up to, and including, decertification of the provider agency, which would result in revocation of the approval of the provider as a BPHC provider agency.

Section 18: BPHC Service Billing

This section outlines the Behavioral and Primary Healthcare Coordination (BPHC) service billing guidelines, claim format, and necessary billing-related information. Moreover, an explanation of actual time spent conducting service versus time billed, modifiers, and other helpful billing-related items are included with examples. Indiana Health Coverage Programs (IHCP) providers are responsible for reading and understanding portions of the *Indiana Administrative Code (IAC)* and manuals and modules that apply to their areas of services. Managed care programs that are eligible for BPHC are billed as fee for service as well. For more information about general billing, see *405 IAC 1* and the [Home and Community-Based Services Billing Guidelines](#) module.

Billing Standards

BPHC provider agencies are Medicaid-eligible billing agencies. As such, provider agencies are bound to adhere to all Medicaid billing rules, policies, and processes. In regard to the BPHC service, the following applies:

- IHCP rendering Provider IDs are assigned to physicians or health service providers in psychology (HSPPs). The rendering Provider IDs are linked to the group Provider ID of the participating billing group.
- Reimbursement is 100% of the rate for all staff meeting provider qualifications for each service type (that is, Tier 1 and Tier 2).
- Providers are responsible for internally tracking BPHC service utilization to ensure that service units are available. Providers may confirm service unit availability via the IHCP Provider Healthcare Portal (Portal), the State's recognized final reference for this information.
- Units of the BPHC service, as displayed in the Portal, are decremented based on adjudicated claims. Failure to submit claims in a timely fashion may place the provider at risk for nonpayment.
- For a BPHC provider to receive reimbursement for the delivery of BPHC service activities, a member must have been deemed eligible for the BPHC service and must have received an authorization notification confirming the BPHC service is authorized on the Individualized Integrated Care Plan (IICP)
- Providers may access BPHC service approval and authorization dates on the IHCP [Provider Healthcare Portal](#), accessible from the home page at in.gov/medicaid/providers.

When billing Medicaid HCBS claims, the provider must consider the following:

- The IHCP do not reimburse time spent by office staff billing claims.
- Providers may bill only for those services authorized on an approved Notice of Action (NOA).
- A claim may include dates of service within the same month. Claims may not be submitted with dates that span more than one month on the same claim.
- The units of service as billed to the IHCP must be substantiated by documentation in accordance with the appropriate *Indiana Administrative Code (IAC)* regulations and the 1915(i) documentation standards issued by the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) and the FSSA Division of Mental Health and Addiction (DMHA).
- Services billed to the IHCP must meet the service definitions and parameters as published in the aforementioned rules and standards.

Updated information is disseminated through IHCP provider bulletins posted on the [Bulletins](#) page at in.gov/medicaid/providers and announcements on the [DMHA website](#) at in.gov/fssa. Each provider is

responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Claim Form

BPHC claims are billed on the paper *CMS-1500* claim form (Centers for Medicare & Medicaid Services authorized professional claim form) or electronically via the 837P transaction or the Provider Healthcare Portal professional claim submission option. The Portal is an interactive web application that allows providers to access *CoreMMIS* (Indiana's Medicaid Management Information System) through the Internet. The Portal is fast, free, and does not require special software. For detailed billing instructions, see the [Claim Submission and Processing](#) and [Provider Healthcare Portal](#) modules at in.gov/medicaid/providers.

Updated information is disseminated through IHCP provider bulletins posted on the [Bulletins](#) page at in.gov/medicaid/providers. Each provider is responsible for obtaining the information and implementing new or revised policies and procedures as outlined in these notices.

Facility Fees

No facility fees are paid for the BPHC service.

BPHC and the Healthy Indiana Plan

Individuals who are enrolled in Healthy Indiana Plan (HIP) 2.0 and are determined to be medically frail have access to coverage established under the Indiana Medicaid State Plan. The State Plan services include intensive behavioral health Medicaid programs such as Medicaid Rehabilitation Option (MRO)/BPHC/Adult Mental Health Habilitation (AMHH). The intensive community-based behavioral health service programs are carved out from the HIP managed care entities' (MCEs') benefit responsibilities and are billed to the IHCP through the fee-for-service claims payment system.

HIP members deemed medically frail will receive HIP State Plan coverage and will be enrolled in *HIP State Plan – Plus*, and are required to make monthly Personal Wellness and Responsibility (POWER) Account contributions. *HIP State Plan – Plus* members are not subject to copays for most services, including the BPHC behavioral health service. Medically frail members enrolled in *HIP State Plan – Plus* who do not pay their monthly POWER Account contributions will be enrolled in *HIP State Plan – Basic*, and are required to pay a \$4 copay for outpatient services; however, the BPHC service is exempt from this copay. No copay is required for the BPHC service for individuals enrolled in *HIP State Plan – Basic*.

More information about the HIP program can be found at the [Healthy Indiana Plan](#) page at in.gov/fssa/hip.

Time Documentation

Staff must document actual time spent delivering services in a 24-hour period within the member's clinical record. For billing purposes, a provider agency must total actual time delivering the same service on the same day by all provider types for each member. Minutes of service do not have to be consecutive to be billed together.

Rounding Minutes to Units

Providers may round the total actual time each day, as described previously, to the nearest whole unit when calculating reimbursement.

15-Minute Unit

If staff delivers a service for 8 or more minutes, or the total daily minutes for the service add up to 8 or more minutes, the provider may round up to one 15-minute unit. If staff delivers a service for 7 minutes or less, or the total daily minutes for the service add up to 7 minutes or less, the provider rounds down to zero units and therefore, may not bill for the service. Providers must add actual time together (as described in the [Time Documentation](#) section) before rounding.

Modifiers for BPHC Services

The following modifiers are needed for the submission of BPHC claims.

Table 7 – Service Modifiers for BPHC Services

Modifier	Service Description
UC	Case management for BPHC
UC U3	Case management for BPHC – DMHA certified Community Health Worker and/or Certified Peer Recovery Specialist

Midlevel Provider Modifiers

Midlevel provider modifiers should not be used when submitting BPHC service claims. The use of midlevel provider modifiers results in the denial of the BPHC service claim.

Third-Party Liability Requirements

The IHCP will not bill private insurance carriers through the third-party liability (TPL) or reclamation processes for claims containing any HCBS benefit modifier codes. This billing practice includes modifiers specific to claims for the BPHC benefit plan.

Financial Oversight

The state of Indiana uses a variety of means for financial oversight, including, but not limited to: audits, oversight to ensure consistency, and fraud control.

HCBS Audits

The state of Indiana employs a hybrid program integrity (PI) approach to overseeing HCBS programs, incorporating oversight and coordination by the Surveillance and Utilization Review (SUR) Unit, as well as engaging the full array of technology and analytic tools available through the Fraud and Abuse Detection System (FADS) contractor arrangements. The FSSA has expanded its PI activities using a multifaceted approach to SUR activity that includes provider self-audits, desk audits, and on-site audits. SUR is required to complete an initial assessment of each provider type annually. Then, based on the assessment information and referrals, audits are completed as needed. The FADS team analyzes claims data, allowing them to identify providers and claims that indicate aberrant billing patterns and other risk factors.

The PI audit process uses data mining, research, identification of outliers, problematic billing patterns, aberrant providers, and issues that are referred by other divisions and State agencies. In 2011, the state of Indiana formed a Benefit Integrity Team comprising key stakeholders that meet biweekly to review and approve audit plans and provider communications, and to make policy and system recommendations to affected program areas. The Surveillance and Utilization Review (SUR) Unit also meets with all (HCBS

divisions on a quarterly basis, at a minimum, and receives referrals on an ongoing basis to maintain open lines of communication and understanding in specific areas of concern, such as policy clarification.

The SUR HCBS specialist is a subject-matter expert (SME) responsible for directly coordinating with the HCBS divisions. This specialist also analyzes data to identify potential areas of risk and identify providers that appear to be outliers warranting review. The SME may also perform desk or on-site audits and be directly involved in reviewing HCBS providers and programs.

Throughout the entire Program Integrity (PI) process, the FSSA maintains oversight. Although the Fraud and Detection System (FADS) contractor may be incorporated in the audit process, no audit is performed without the authorization of the FSSA. The FSSA's oversight of the contractor's aggregate data is used to identify common problems to be audited, determine benchmarks, and offer data to peer providers for educational purposes, when appropriate.

The SUR Unit offers education regarding key program initiatives and audit issues at waiver provider meetings to promote ongoing compliance with federal and State guidelines, including all IHCP and HCBS requirements.

FSSA Audit Oversight

The Audit Division of the FSSA reviews HCBS audit team schedules and findings to reduce redundancy and assure use of consistent methodology.

Medicaid Fraud Control Audit Overview

The Indiana Medicaid Fraud Control Unit (MFCU) is an investigative branch of the Attorney General (AG) Office. MFCU conducts investigations in the following areas:

- Medicaid provider fraud
- Misuse of Medicaid members' funds
- Patient abuse or neglect in Medicaid facilities

When the MFCU identifies a provider that has violated regulations in one of these areas, the provider's case is presented to the State or federal prosecutors for appropriate action. Providers can access information about the MFCU from the [Medicaid Fraud](https://www.in.gov/attorneygeneral/medicaid-fraud) page at [in.gov/attorneygeneral](https://www.in.gov/attorneygeneral).

Place of Service Codes

BPHC service activities can be rendered in the following locations with the place of service code listed:

Table 8 – BPHC Place of Service Codes

Code	Location
12	Home
99	Other unlisted facility (such as employment or a community place)
53	Community Mental Health Center (CMHC)

Mailing Address for Claims

BPHC paper claims are sent to the standard medical claim address at DXC:

CMS-1500 Claims
P.O. Box 7269
Indianapolis, IN 46207-7269

Additional Addresses and Telephone Numbers

Providers should direct questions about filing claims to Customer Assistance toll-free at 1-800-457-4584. The addresses and telephone numbers are also available on the [IHCP Quick Reference Guide](#) at in.gov/medicaid/providers.

Appendix A: BPHC Acronyms and Definitions

The following acronyms and definitions apply to the Behavioral and Primary Healthcare Coordination (BPHC) program and the policies and procedures outlined in this module:

837P electronic transaction allows providers to submit professional claims electronically to the Indiana Health Coverage Programs (IHCP). The 837P transaction can be used instead of the Provider Healthcare Portal (Portal) professional claim or the *CMS-1500* paper claim form.

Adult Needs and Strengths Assessment tool (ANSA) is the approved Division of Mental Health and Addiction (DMHA) behavioral health assessment tool, administered by a qualified individual who is trained and DMHA-certified to administer the tool to assist in determining the level of need (LON) and functional impairment of an applicant or member.

Aged and Disabled (A&D) Waiver provides an alternative to nursing facility admission for people who are aged, blind, or disabled. There is no age requirement to qualify for this waiver. The waiver is designed to provide services to supplement informal supports for people who would require care in a nursing facility if waiver services or other supports were not available.

Applicant means an individual applying for the BPHC service by inquiring about the BPHC service or completing the BPHC application process.

Assistance means any kind of support given due to a behavioral health condition or disorder. This support includes, but is not limited to, the following:

- Mentoring
- Supervision
- Reminders
- Verbal cueing
- Hands-on assistance

Authorized healthcare professional (AHCP) means any of the following persons:

- A physician's assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *Indiana Code IC 25-27.5-5*
- A nurse practitioner (NP) or clinical nurse specialist (CNS) with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23-1*

Behavioral and Primary Healthcare Coordination (BPHC) refers to coordination of healthcare services to manage the healthcare needs of the member, including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services.

Care coordinator means the DMHA-approved BPHC provider staff overseeing or managing the BPHC service member's case while the individual is enrolled in the BPHC program.

Centers for Medicare & Medicaid Services (CMS) is the federal agency that has authority over the 1915(i) State plan amendments in each state. The CMS must approve the State's requests to implement the federally funded State Plan Amendment and all subsequent program amendments and funding.

Certified community health worker (CHW) refers to an individual who is certified to deliver services as defined at *405 IAC 5-21.8-8(a)*. To be certified as a CHW, an individual must have completed the CHW

DMHA and Indiana State Department of Health (ISDH) State-approved training program and received a passing score on the certification exam. The CHW is supervised by a licensed professional (LP) or qualified behavioral health professional (QBHP) (as defined in this section) and remains in good standing.

Certified recovery specialist (CRS) refers to an individual who is certified to deliver services as defined at 405 IAC 5-21.8-8(f). To be certified as a CRS, an individual must be maintaining healthy recovery from mental illness and must have completed the CRS DMHA State-approved training program and received a passing score on the certification exam. The CRS is supervised by a licensed professional or qualified behavioral health professional (as defined in this section) and remains in good standing.

CMS-1500 is the Centers for Medicare & Medicaid Services (CMS)-authorized professional claim form used to submit paper claims to the Medicaid fiscal contractor for reimbursement of rendered, DMHA-approved home and community-based services (HCBS).

Community-based refers to BPHC services approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within the individual's home (or place of residence), or at other locations based in the community (outside institutional settings).

Community Integration and Habilitation (CIH) Waiver provides services that enable individuals with developmental disabilities to remain in their homes or in community settings and assists people who transition from state-operated facilities or other institutions into community settings. This waiver is designed to provide supports for persons to gain and maintain optimum levels of self-determination and community integration while allowing flexibility in the provision of those supports.

Community mental health center (CMHC) is approved as such by the DMHA under 440 IAC 4.1-2-1. The centers offer communities access to a full continuum of behavioral health services.

Consumer Service Line is a toll-free line for consumers to share complaints, questions, and concerns about services, treatments, procedures, rights, and policies. The line is open Monday-Friday from 8:30 a.m. to 5 p.m. The DMHA contractor processes calls and informs the DMHA. The toll-free number is 1-800-901-1133. Deaf, hard-of-hearing, or speech-impaired individuals can dial 7-1-1 to access the Consumer Service Line.

CoreMMIS is Indiana's Medicaid Management Information System (MMIS) or claim-payment system. CoreMMIS replaced IndianaAIM.

CMHC provider owned, controlled, or operated (POCO) residential setting is a specific physical place where a member lives that is owned, leased, or co-leased by a CMHC provider of Home and Community-Based Services (HCBS).

Data Assessment Registry Mental Health and Addiction (DARMHA) supports the use of information about the strengths and needs of individuals to help make decisions, to monitor progress and to improve quality. DARMHA is also the system by which the BPHC application is entered and submitted to the DMHA for review.

Division of Aging (DA) is the division within the Indiana Family and Social Services Administration (FSSA) that oversees two 1915(c) Home and Community-Based Services (HCBS waiver programs: the Aged and Disabled (A&D) Waiver and the Traumatic Brain Injury (TBI) Waiver. The DA is also responsible for administering the Money Follows the Person (MFP) demonstration grant and processing Preadmission Screening and Resident Review (PASRR) requests.

Division of Family Resources (DFR) is the division within the Indiana Family and Social Services Administration (FSSA) responsible for processing applications and approving eligibility for Medicaid, Temporary Aid for Needy Families (TANF, or cash assistance), child care assistance, Supplemental Nutrition Assistance Program (SNAP, or food stamps), and employment and training services for low-income clients.

Division of Mental Health and Addiction (DHMA) is the division within the Indiana Family and Social Services Administration (FSSA) with responsibility for the daily operation of the BPHC program.

DXC Technology (DXC) is the Indiana Medicaid fiscal agent responsible for maintaining the Core Medicaid Management Information System (*CoreMMIS*) database for all Medicaid participants, provider enrollment, authorized Indiana Health Coverage Programs (IHCP) services, IHCP claim processing, and reimbursement for eligible IHCP providers. This includes all approved HCBS participants, DMHA-approved services, and enrolled providers of HCBS. DXC assigns all IHCP Provider IDs required for reimbursement of all IHCP claims. DXC also maintains the IHCP provider reference modules for all IHCP providers.

Family and Social Services Administration (FSSA) is the Indiana state agency that includes the Division of Aging (DA), Division of Disability and Rehabilitation Services (DDRS), Division of Family Resources (DFR), Division of Mental Health and Addiction (DMHA), and Office of Medicaid Policy and Planning (OMPP).

Family Supports Waiver (FSW) provides limited, nonresidential supports to individuals with developmental disabilities who live with their families or in other community settings with informal supports.

Fraud and Detection Systems (FADS) is a means established by a Medicaid agency that maintains methods, criteria, and procedures that meet all requirements of *42 CFR 455.13* through 455.21 and 455.23 for prevention and control of program fraud and abuse.

Habilitation services means activities that are designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in community settings

Health means physical and behavioral well-being.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) refers to mandated requirements for the adoption of national standards for healthcare, including the protection of health information and standard unique identifiers for all healthcare providers, as well as coding healthcare services for approving, billing, reimbursing, and tracking.

Health service provider in psychology (HSPP) as defined by *IC 25-33-1*.

Home and Community-Based Services (HCBS) refers to services approved by the Centers for Medicare & Medicaid Services (CMS) to be provided within the Medicaid member's home (or place of residence) or at other locations based in the community (outside the institutional setting). For Medicaid purposes, *HCBS* generally refers to home and community-based services programs authorized by CMS under Section 1915(c) of the *Social Security Act*.

Indiana Administrative Code (IAC) refers to the Indiana State policy and procedures.

Indiana Code (IC) consists of Indiana State statutes that govern the IAC.

Indiana Health Coverage Programs (IHCP) is Indiana's Medicaid program, collectively referred to as the Indiana Health Coverage Programs (IHCP). The IHCP provides a healthcare safety net for low-income children and adults, including those who are aged, disabled, blind, pregnant, or meet other eligibility requirements. The IHCP receives federal and State funds to operate the program and reimburse providers for reasonable and necessary medical care for eligible members. Each state administers its own Medicaid program within the provisions of federal legislation and broad federal guidelines issued by the Centers for Medicare & Medicaid Services (CMS). The Indiana Family and Social Services Administration (FSSA) administers the IHCP. The IHCP includes the 590 Program, Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, including Children's Health Insurance Program (CHIP), and Traditional Medicaid.

Individualized Integrated Care Plan (IICP) means a treatment plan that:

- Integrates all components and aspects of care that are:
 - Deemed medically necessary
 - Needs-based
 - Clinically indicated
 - Provided in the most appropriate setting to achieve the member’s goals
- Includes all indicated medical and support services needed by the member to:
 - Remain in the community
 - Function at the highest level of independence possible
 - Achieve goals identified in the IICP
- Is developed for each member
- Is developed with the member
- Reflects the member’s desires and choices

Individual provider is a provider that practices privately and not under an agency.

Level of need (LON) means a recommended intensity of behavioral health services, based on a pattern of an individual’s and family’s needs, as determined by using the DMHA-approved behavioral health standardized assessment tool, the Adult Needs and Strengths Assessment (ANSA).

Licensed professional means any of the following persons:

- Licensed physician (including licensed psychiatrist)
- Licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP)
- Licensed clinical social worker (LCSW)
- Licensed mental health counselor (LMHC)
- Licensed marriage and family therapist (LMFT)
- Licensed clinical addiction counselor (LCAC), as defined under *Indiana Code IC 25-23.6-10.5*

Managed care entity (MCE) is an entity contracted to provide and manage benefits for members enrolled in a managed care program, such as the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. In a full-risk contract, the MCE agrees to provide all benefits on a per-member per-month basis, known as full capitation.

Medicaid Rehabilitation Option (MRO) services means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for the maximum reduction of physical or mental health disability and restoration of a member to his or her best possible level of functioning.

Member means an individual who has been approved by the DMHA SET for the BPHC service and Medicaid.

Member ID is the member identification number, also known as RID, used to identify individuals eligible for Indiana Health Coverage Programs (IHCP) services, including tracking and claim processing for eligible services.

Money Follows the Person (MFP) is a demonstration grant to help move individuals from institutional settings to home and community-based settings.

National Provider Identifier (NPI) is the 1996 Health Insurance Portability and Accountability Act (HIPAA)-mandated standard unique identifier for all healthcare providers. Unique NPIs are assigned by

application to the National Plan and Provider Enumeration System that collects identifying information on healthcare providers. (**Note:** An assigned NPI is not needed for BPHC service providers that do not perform healthcare services. HCBS providers may submit claims using their Provider ID.)

Needs-based eligibility criteria are factors used to determine an applicant's requirement for BPHC service activities. The applicant meets the BPHC needs-based eligibility criteria when the following is demonstrated:

- Needs related to management of his or her health
- Impairment in self-management of health services
- A health need that requires assistance and support in coordinating health treatment
- A recommendation for intensive community-based care based on the uniform DMHA-approved behavioral health assessment tool, as indicated by a rating of 3 or higher

Non-CMHC provider owned, controlled or operated (POCO) residential setting is a specific physical place where a member lives that is owned, leased, or co-leased by a provider of HCBS *other than a CMHC*.

Non-POCO residential setting refers to settings owned, controlled, or operated by either a not-for-profit organization or an independent setting operating authority rather than a CMHC.

Nonprofessional caregiver means any individual who does not receive compensation for providing care or services to a Medicaid member.

Notice of Action (NOA) (*State Form-HCBS Form 5*) is a written notice given to each HCBS applicant and participant for any action that will affect his or her HCBS benefits. The NOA includes actions to approve or deny an applicant's eligibility for HCBS; all DMHA-approved Child Mental Health Wraparound (CMHW) benefits; all subsequent changes to increase, reduce, or terminate any or all HCBS; the effective dates and reasons for the actions taken; and the individual's appeal rights. The designated service providers also receive a copy of the NOA for prior authorization to provide and bill the IHCP for the DMHA-approved services. The IHCP will deny reimbursement for any service that is not listed on the NOA or exceeds the DMHA-approved amount of each service.

Office of Medicaid Policy and Planning (OMPP) is the division within the Indiana Family and Social Services Administration (FSSA) that administers the IHCP in accordance with federal and State requirements, which includes responsibility for financial oversight of the Home and Community-Based Services (HCBS) program.

Other behavioral health professional (OBHP) means any of the following:

- An individual with an associate's or bachelor's degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional or a qualified behavioral health professional (QBHP).
- A licensed addiction counselor, as defined under *IC 25-23.6-10.5*, supervised by either a licensed professional or a QBHP.

Outpatient mental health services refers to services defined under *405 IAC 5-20-8*, formerly referred to as "Medicaid Clinic Option" services.

Participant refers to an individual who has been deemed eligible for HCBS services by the DMHA.

Physician consults, in the context of the BPHC service, is defined as facilitating linkage and communication between medical providers.

Provider agency means any of the DMHA state-certified Community Mental Health Centers (CMHCs) that meet required qualifications and criteria that can employ rendering providers to deliver the BPHC service.

Provider Healthcare Portal (Portal) is a secure, web-based tool where BPHC providers may view BPHC authorization, claim, and other information. Provider enrollment, provider profile updates, and claims (including claims for DMHA-approved BPHC services rendered) may also be submitted via the Portal. The [Portal](#) is accessible from the home page at in.gov/medicaid/providers. For more information about using the Portal, see the [Provider Healthcare Portal](#) module.

Provider ID is a unique identifier, formerly referred to as the Legacy Provider Identifier (LPI), assigned to IHCP-enrolled providers, including service providers, for submission of all claims for IHCP reimbursement. This number is assigned by the Medicaid fiscal agent during the provider enrollment process.

Provider staff means any individual working under a DMHA-approved BPHC provider agency that meets the qualifications and requirements mandated by the BPHC service being provided.

Provider owned, controlled, or operated (POCO) refers to the DMHA reference to Community Mental Health Centers (CMHC) HCBS service locations and residential settings for HCBS members. However, POCO, as defined by the Centers for Medicare & Medicaid Services (CMS), applies to all settings that a HCBS member resides in or receives services in and any provider, not just CMHCs.

Qualified behavioral health professional (QBHP) means any of the following:

- An individual who has had at least 2 years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines from an accredited university:
 - Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana
 - Pastoral counseling
 - Rehabilitation counseling
- An individual who is under the supervision of a licensed professional and is eligible for and working toward professional licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines from an accredited university:
 - Social work from a university accredited by the Council on Social Work Education
 - Psychology
 - Mental health counseling
 - Marital and family therapy
- A licensed independent practice school psychologist under the supervision of a licensed professional (LP).
- An authorized healthcare professional (AHCP) who is one of the following:
 - A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of *IC 25-27.5-5*.
 - A nurse practitioner (NP) or clinical nurse specialist (CNS), with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician, pursuant to *IC 25-23-1*.

Residential Settings Screening Tool (RSST) is the DMHA HCBS tool used to screen for HCBS compliance in a member's current living situation.

Recreational means activities people do to relax or have fun (for example, activities done for enjoyment).

Serious Mental Illness (SMI) refers to persons (18 years of age or older) with serious and long-term mental disorders that impair their capacity for self-care, interpersonal relationships, work, and schooling.

State Evaluation Team (SET) means the DMHA independent evaluation team that reviews and assesses all evaluation information and supporting clinical documentation collected for BPHC applicants and members, and is responsible for making final determinations regarding the following:

- Needs-based and target group eligibility of applicants for the BPHC service
- Authorization for the BPHC service for eligible members
- Continued eligibility determination for BPHC members
- Appropriate service delivery to BPHC members, as a result of conducting quality improvement reviews of BPHC service provider agencies

Target Group Eligibility Criteria are factors used to determine an applicant's eligibility for the BPHC service. To meet the BPHC target group criteria, an applicant must be age 19 or older, and be diagnosed with a BPHC eligible primary mental health diagnosis.

Traumatic Brain Injury (TBI) Waiver provides services to Medicaid-eligible people of any age who have experienced an external insult resulting in a traumatic brain injury and require services ordinarily available only in a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

1. *Journal of the American Medical Association*, 1997; 277: 1033-1036.

The applicant must be asked if he or she is participating in a Home and Community-Based Services (HCBS) waiver program. As described in [Section 14: Behavioral and Primary Healthcare Coordination](#), (BPHC) service providers are responsible, in collaboration with 1915(c) HCBS waiver providers, for monitoring services of BPHC members also enrolled in a 1915(c) waiver program to prevent service duplication. Using the pull-down menu, the BPHC provider must select the appropriate option.

Figure 2 – Page 1 of BPHC Application – General Tab (Current Living Situation)

Current Living Situation :

Community-based Settings:

- ☐ Homeless
- ☐ Private/Independent Home
- ☐ Non-POCO Residential setting
- ☐ Non-CMHC POCO Residential setting
- ☐ POCO Residential Setting
- ☐ Potential Presumed Institutional setting

Institutional Settings:

- ☐ Nursing Home
- ☐ Hospital
- ☐ Institution for Mental Disease (IMD)
- ☐ ICF/IID
- ☐ Jail/Correctional Facility

Figure 2 shows the *Current Living Situation* section of the application. Click to select the circle (radio button) next to the applicable current living situation **as of the day the application is being completed**. For definitions of community-based and institutional settings, see [Section 4: Home and Community-Based Residence Requirements](#) and [Section 7: Completing the HCBS Residential Setting Screening Tool](#) in this module.

Figure 3 – BPHC Application View – IICP Form Tab

Treatment Team Attestation :

- ☐ The applicant has been given choice of providers
- ☐ The applicant has been given choice of services
- ☐ The proposed IICP is individualized to meet the applicant's need
- ☐ The applicant has participated in the development of the IICP
- ☐ A copy of the IICP that was submitted with this application was offered to the applicant and/or legal guardian
- ☐ Program requirements, including financial requirements, have been reviewed with the applicant
- ☐ The HCBS Residential Setting Screening Tool has been completed with the applicant, a signed copy retained in the clinical record, and the HCBS Member Information Pamphlet was provided to the applicant

Figure 3 shows the attestation options. The applicant or the legal guardian and the case manager or the referring care coordinator must sign the attestations. (The [HCBS member information pamphlet](#) is available at in.gov/fssa/dmha.)

In addition to the preceding attestations, a signature from the Adult Needs and Strengths Assessment (ANSA) SuperUser reviewing the ANSA must be documented in the clinical record. The date the ANSA SuperUser signs the attestation documenting his or her review must be entered in the application.

Note: Hard-copy or electronic signatures from the applicant, legal guardian (if applicable), case manager, referring care coordinator, and reviewing Adult Needs and Strengths (ANSA) SuperUser must be kept in the member's clinical chart and made available for review by the State Evaluation Team (SET) during quality assurance (QA) site visits. The date of the signature on the attestation must match the date of attestation entered on the Behavioral and Primary Healthcare Coordination (BPHC) application.

Appendix C: CMHC Provider Application and Attestation to Provide BPHC

Figure 4 – CMHC Provider Application and Attestation to Provide Behavioral and Primary Healthcare Coordination (BPHC)

<p style="text-align: center;">CMHC PROVIDER APPLICATION AND ATTESTATION TO PROVIDE BEHAVIORAL AND PRIMARY HEALTHCARE COORDINATION (BPHC)</p> <p>I, _____, CEO of _____ CMHC, attest to the following: _____ CMHC is:</p> <ol style="list-style-type: none">1) A DMHA-certified Community Mental Health Center (CMHC) in good standing;2) A provider currently enrolled in the Indiana Medicaid program;3) Willing and able to provide BPHC services as described in the 1915(i) State Plan Amendment (SPA) (13-013), BPHC rule (405 IAC 5-21.8), the BPHC Provider Module, and any subsequent amendments to these documents, to meet the identified healthcare management needs of each eligible member; and4) Committed to ensuring that members have access to the services and supports needed to meet his/her individual needs. <p>The signature below attests that _____ CMHC requests to become a DMHA-approved BPHC service provider in the state of Indiana.</p> <table border="0" style="width: 100%;"><tr><td style="width: 50%; text-align: center;">_____ <i>Community Mental Health Center CEO</i></td><td style="width: 50%; text-align: center;">_____ <i>Date</i></td></tr><tr><td colspan="2">_____ Printed Name</td></tr></table>	_____ <i>Community Mental Health Center CEO</i>	_____ <i>Date</i>	_____ Printed Name	
_____ <i>Community Mental Health Center CEO</i>	_____ <i>Date</i>			
_____ Printed Name				

Appendix D: BPHC Application Status Codes

Table 9 provides the status codes that are viewable in the *Application Status* field of the Behavioral and Primary Healthcare Coordination (BPHC) application in Data Assessment Registry Mental Health and Addiction (DARMHA). The status code is updated whenever a new action is taken on a BPHC application. Providers can use this code to track where an application is in the process.

Table 9 – Rating Guidelines

Status Code	Description
Discarded	The application was discarded by the provider or was in draft mode for more than 60 days and was discarded by the State Evaluation Team (SET). Applications discarded for either reason have not been submitted for review by the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) SET.
Draft	A draft was saved by the provider. The application has not yet been submitted for review by the DMHA SET.
Submitted	The application was submitted by the provider and is undergoing the DMHA SET review. The SET has 10 business days to review an application and render a decision.
DMHA Pending	The application was pended by the DMHA SET for review and potential updates to be made by the provider (that is, the supporting documentation is inconsistent or insufficient for the DMHA SET to make a clinical eligibility determination). If the pended applications are not resubmitted within 7 calendar days from the date that the SET pended the application, the application will be subject to denial.
DMHA Approved	The application has been clinically approved by the DMHA SET and will be forwarded to the Division of Family Resources (DFR) for review of non-clinical Indiana Health Coverage Programs (IHCP) eligibility.
DMHA Denied	The application has been clinically denied by the DMHA SET. Therefore, the individual is not BPHC-eligible. The provider needs to review and reach out to the client for next steps.
Modifications Approved	The DMHA SET has approved updates to an application that was previously pended.
DFR Pending	Clinically approved application has been sent to the DFR for nonclinical IHCP eligibility determination. The application is being reviewed by the DFR, and so eligibility questions should be directed to the DFR.
DFR Approved	The application has been clinically approved by the DMHA SET and approved by the DFR for IHCP eligibility. The file will be sent to DXC (the Indiana Medicaid fiscal agent) for service package assignment.
DFR HP Conditional	The applicant was clinically approved by the DMHA SET and the individual was determined to meet IHCP criteria by the DFR. However, IHCP coverage has not yet been activated due to an outstanding required action that needs to be completed. There may be issues such as a form missing, an appointment missed, premium not received, and so on. BPHC provider agencies should follow their normal protocols for assisting consumers with IHCP eligibility.

Status Code	Description
DFR Denied	The application has been clinically approved by the Division of Mental Health and Addiction (DMHA) State Evaluation Team (SET) but the Division of Family Resources (DFR) found the individual ineligible for Indiana Health Coverage Programs (IHCP). Therefore, the individual is not currently BPHC-eligible.
DFR Mismatch	Applicant data (such as date of birth, Social Security number, and name) entered in DARMHA does not match the information in the Indiana Client Eligibility System (ICES). The DMHA will notify the BPHC provider agency if action is required by the provider to update the applicant's record in DARMHA.
HP Data Sent	The applicant was clinically approved by the DMHA SET and met IHCP eligibility criteria with the DFR. This information has been sent to DXC (the Indiana Medicaid fiscal agent) for service package assignment.
HP End Date Changed	A BPHC service package was created by DXC and adjusted to align with the Medicaid Rehabilitation Option (MRO) end date.
HP Processed	The individual is fully approved for BPHC and a service package assignment has been generated. BPHC start and end date and assigned units are viewable in the IHCP Provider Healthcare Portal (Portal).
Not Approvable	The submitted application is beyond its end date and has expired.

Appendix E: BPHC Application Report

The Data Assessment Registry Mental Health and Addiction (DARMHA) system can generate a report indicating the status of all submitted Behavioral and Primary Healthcare Coordination (BPHC) applications:

1. Navigate to the main BPHC application search page by choosing BPHC from the main DARMHA menu. At the BPHC application search page, an empty box labeled **Application Status** has a drop-down menu showing all the available BPHC application status codes.
2. Select a status code to conduct a query of only the BPHC applications that have been assigned that particular status code. If no status code is chosen, all applications created will be listed.
3. Choose **Print Search Result** to generate a report that can be viewed onscreen.
4. To print the report, select the printer icon at the top of the page.
5. To export the report, select the desired file format from the drop-down menu at the top of the screen and select **Export**. Choose **Open** or **Save** from the dialog box.

To exit the report, choose **Close Report** to return to the BPHC main screen.

DARMHA also has the capability to generate a report that is useful in tracking the BPHC package end dates to identify members approaching the submission period to ensure timely submittal of renewal applications and a report that identifies applications that have ended with no BPHC renewal application submitted. The following steps indicate how to generate these reports:

1. Navigate to the main DARMHA screen.
2. Select **Reports** from the menu.
 - a. To identify BPHC applications that have expired and with no new application being submitted, select **BPHC Expired Application No Renewal**.
 - b. To identify current BPHC applications and their expiration dates, select **BPHC Expiring Applications**.

Appendix F: Residential Setting Screening Tool

Members who receive services through the Adult Mental Health and Habilitation (AMHH) or the Behavioral and Primary Healthcare Coordination (BPHC) program are required to live and receive home and community-based services (HCBS) in settings that meet federal Medicaid guidelines for HCBS. The HCBS Residential Setting Screening Tool (RSST) tool is intended to help members and providers identify the type of setting where a member lives. Every application (initial or renewal) for BPHC or AMHH services is required to have an RSST completed in its entirety and be kept in the member's clinical record. When a member has a change in address, an RSST must also be completed within 15 calendar days of staff becoming aware of the change in the member's living situation. An updated copy of this screening tool, along with the member's and staff's signature must be kept in the member's clinical record.

As of July 1, 2018, providers are no longer required to submit an updated RSST to the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) when they change addresses, but the form will need to be updated and maintained in the client's medical record. In addition, the *Non-Community Mental Health Center (CMHC) provider owned, controlled, or operated (POCO)* residential type POCO residences other than CMHCs was added to the updated RSST to reflect the change made in the Data Assessment Registry Mental Health and Addiction (DARMHA) application.

RSST Information and Definitions

The following sections provide general instructions, definitions of terms used in the tool, and additional information for members and provider staff completing the tool. Specific instructions and directions are located within each section of the RSST.

General Information and Instructions

The RSST removes the requirement for providers to independently assess the HCBS compliance of residential settings (other than private/independent homes). Because HCBS compliance information has already been reported for all currently identified CMHC POCO residential settings and will begin to be collected for identified non-POCO residential settings, it is no longer necessary for providers to "reassess" these settings every 6 months. The RSST has been redesigned to ensure that providers are able to accurately identify and report (via the DARMHA application) the *type* of residential setting in which an AMHH or BPHC applicant lives.

The RSST is used in conjunction with the *Non-POCO Residential Setting Worksheet* and the *Non-CMHC POCO Residential Setting Worksheet*. Non-POCO residential settings such as unlicensed assisted-living facilities must be assessed using this packet, to ensure that they also meet HCBS requirements for residential settings not owned, controlled, or operated by a CMHC. The non-CMHC POCO residential settings can also be assisted-living settings but that are under the authority of the Division of Aging (DA) and/or the Division of Disability and Rehabilitative Services (DDRS). **If, during completion of the RSST, an agency determines that the applicant lives in one of these settings and the setting has not been assessed for HCBS compliance, the assessment must be completed within 30 days from the date the DARMHA application was submitted.** Note that non-POCO and non-CMHC POCO residential settings need to be assessed only one time. They do not need to be reassessed unless a significant change or modification to the setting occurs, which impacts its HCBS compliance status.

Although residential settings are only required to be assessed once for HCBS compliance (barring any significant changes at the setting), the RSST must be completed with every member applying for AMHH or BPHC during the assessment process for every application (initial and renewal). The RSST must be completed before the DARMHA application is completed and submitted, because information from the RSST must be included in the DARMHA application. Upon the provider agency learning of a change in a member's living situation, the RSST must be completed, signed by the member, and placed in the clinical record.

The sections of the RSST are to be completed *in order*, until the member's living situation type has been accurately identified. The member's identifying information is entered, and the member and referring care coordinator proceed in order through the sections, beginning with Section 1. After the member's living situation has been accurately identified, and the member and case manager have signed in the appropriate section, the tool is complete. The type of residential setting in which the member lives as documented on the RSST is transferred to the *Current Living Situation* section of the DARMHA application for AMHH and/or BPHC for the member.

Definitions of Settings

The following sections define the terms used in the current RSST:

Homeless

Homeless is defined as:

- Lacking a fixed, regular, and adequate nighttime residence, and/or
- The primary nighttime residence is:
 - A supervised publicly or privately operated shelter designed to provide temporary living accommodation of 3 or less months, or
 - A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (for example, on the street)

Note that this definition includes members who temporarily reside in homeless shelters.

Private/Independent Home

An individual's private home (owned or leased), or a relative's home (owned or leased) where the individual resides, is considered to be a *private/independent home*. According to the Centers for Medicare & Medicaid Services (CMS), a state may presume that an individual's private home or a relative's home where an individual resides meets the home and community-based settings requirements; however, it is still the State's responsibility to ensure that individuals living in a private home or a relative's home have opportunities for full access to the greater community.

Four characteristics must be present at a private/independent home:

- The residence is owned or leased/rented by the member or someone in the member's family for his or her personal use.
- The residence affords opportunities for full access to the greater community.
- The residence is not owned or operated by an agency that provides AMHH and/or BPHC services.
- The residence is not located in or on the grounds of a hospital, nursing home, or other facility that provides inpatient institutional care.

Presumed Institutional Setting

Some residential settings are presumed to have qualities of an institution, based on the following characteristics:

- The residence is located in a publicly or privately owned facility that also provides inpatient institutional care.
- The residence is in a building on the grounds of, or immediately adjacent to, a public institution.
- The residence has the effect of isolating individuals receiving AMHH services from the broader community.

CMHC Provider Owned, Controlled, or Operated (POCO) Residential Setting

A *CMHC POCO residential setting* is a specific physical place where a member lives that is owned, leased, or co-leased by a CMHC provider of HCBS. Examples of CMHC POCO residential settings are as follows:

- Supervised group living facilities
- Transitional residential services facilities
- Semi-independent living program facilities defined under *Indiana Code IC 12-22-2-3*
- Alternative family homes operated solely by resident householders

Non-POCO Residential Setting

The DMHA uses the term *non-POCO residential setting* to refer to a setting owned, controlled, or operated by either a not-for-profit organization or an independent setting operating authority rather than a CMHC. However, some settings may meet the Centers for Medicare & Medicaid Services (CMS) definition of provider owned, controlled, or operated and these may be considered POCO residential settings under the authority of other FSSA Divisions. Examples of these types of residential settings include but are not limited to the following:

- Residential care facilities (RCFs); this category includes unlicensed assisted living facilities (ALFs) and adult family care homes (AFCHs)
- County homes
- Cluster homes or cluster apartments owned by nonprofit agencies

Non-CMHC POCO Residential Setting

A *non-CMHC POCO residential setting* is a specific physical place where a member lives that is owned, leased, or co-leased by a provider of HCBS *other than a CMHC*. However, these may be considered POCO residential settings under the authority of other FSSA Divisions.

The Indiana FSSA Division of Aging (DA) and the Division of Disability and Rehabilitative Services (DDRS) administer four other Medicaid HCBS programs, known as 1915(c) Home and Community-Based Services Waivers:

- Traumatic Brain Injury (TBI) Waiver, administered by the DA
- Aged and Disabled (A&D) Waiver, administered by the DA
- Community Integration and Habilitation (CIH) Waiver, administered by the DDRS
- Family Supports Waiver (FSW), administered by the DDRS

A member receiving services under any of these 1915(c) waivers also must live in a setting that is HCBS compliant.

The following figures show the two pages of the current HCBS RSST (as of July 1, 2019).

Figure 5 – HCBS RSST (Page 1)

HCBS Residential Setting Screening Tool <i>Effective July 1, 2019</i>			
<p>Members who receive services through the AMHH and/or BPHC program are required to live and receive HCBS services in settings that meet federal Medicaid guidelines for home and community-based services (HCBS). This tool is required to be completed (1) with every member applying for AMHH and/or BPHC during the development process for every application (initial, renewal, and modification), AND/OR (2) within 15 calendar days of any change in the member's living situation. A completed copy of this screening, with the member's and case manager's signatures in the appropriate section, must be kept with the member's clinical record. In addition, the "Current Living Situation" section on the DARMHA application should reflect the setting identified below.</p>			
Member Name: _____		Date of Screening: _____	
Member's address: _____			
DARMHA ID #: _____	Internal ID #: _____	Benefit: AMHH/BPHC (circle one or both)	
<p>Please check the box that best described the member's living situation:</p>			
<input type="checkbox"/>	<p><u>Identification for Homelessness</u> Homeless is defined as: (1) lacking a fixed, regular, and adequate nighttime residence, and/or (2) the primary nighttime residence is: (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodation of 3 or less months, or (b) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street, tent community?).</p>		
<input type="checkbox"/>	<p><u>Identification for "Private/Independent Home" Setting</u> An individual's private home (owned or leased), or a relative's home where the individual resides (owned or leased).</p>		
<input type="checkbox"/>	<p><u>Identification of a CMHC Provider Owned, Controlled, or Operated (POCO) Residential Setting</u> A provider CMHC owned, controlled, or operated (POCO) residential setting is a specific physical place that is owned, co-owned, and/or operated by a CMHC provider of HCBS.</p>		
<input type="checkbox"/>	<p><u>Identification and Attestation for Non-POCO Residential Setting</u> These are most often residential settings that provide some level of daily living support services, such as (this list is not all-inclusive):</p> <ul style="list-style-type: none"> • Residential Care Facilities County homes • Residential Care Assistance Program (RCAP) facilities • Room and Board Assistance (RBA) facilities • Cluster homes/cluster apartments owned by non-profit agencies 		
<input type="checkbox"/>	<p><u>Identification and Attestation for Non-CMHC POCO Residential Setting</u> A provider of HCBS other than a CMHC may operate or be delivering services at that setting. The Indiana FSSA agencies Division of Aging (DA) and Division of Disability and Rehabilitative Services (DDRS) administer four other Medicaid HCBS programs, known as 1915(c) Home and Community-Based Waivers:</p> <ul style="list-style-type: none"> • Traumatic Brain Injury (TBI; administered by DA) • Aged and Disabled (A&D; administered by DA) • Community Integration and Habilitation (CIH; administered by DDRS) • Family Supports (FS; administered by DDRS) 		
Member Signature _____	Date _____	Case Manager Signature _____	Date _____
Member name (printed) _____		Case Manager name (printed) _____	
<p>***Individuals that reside in a private/independent home, please skip the questions below***</p>			

Figure 6 – HCBS RSST (Page 2)

RSST Ongoing Monitoring Plan

Member Name: _____ Date of Screening: _____

Member's address: _____

DARMHA ID #: _____ Internal ID #: _____ Benefit: AMHH/BPHC (circle one or both)

For ONLY those members that reside in a POCO or non-POCO residential setting, please answer the following questions. If any responses to the following questions are "No," please email this RSST (2nd page) to bphc.services@fssa.in.gov.

1. The setting is integrated in and supports residents full access of to the greater community	
2. The setting is selected by the individual from among setting options	
3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint	
4. Enhances individual initiative, autonomy, and independence in making life choices	
5. Individuals have a choice regarding services and supports, and who provides them	
6. A lease or residency agreement is in place for each HCBS participant and includes protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law	
7. Each individual has privacy in their sleeping or living unit	
8. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time	
9. Individuals are able to have visitors of their choosing at any time	
10. The setting is physically accessible to the individual	

By our signatures, we attest that the member's current living situation is selected correctly and the member answered the exploratory questions (when appropriate).

Member Signature

Member name (printed)

Date

Case Manager name (printed)

Case Manager Signature

Date